MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

EARLY INTERVENTION SERVICES

OPERATIONAL STANDARDS

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I. INTRODUCTION

The Massachusetts Department of Public Health (MDPH) was designated lead agency for Part C (formerly known as Part H) of the Individuals with Disabilities Education Act in 1988. Operational Standards were developed based on Part H of Public Law 102-119, 34 CFR Part 303, Early Intervention Program for Infants and Toddlers with Disabilities, and Massachusetts General Laws, Chapter 111G.

The Massachusetts Early Intervention system is comprised of community-based programs certified as Early Intervention programs by the Massachusetts Department of Public Health. These programs provide comprehensive, integrated services, utilizing a family centered approach, to facilitate the developmental progress of eligible children between the ages of birth to three years old. Eligible children are those children who have a specific diagnosed condition or whose development is delayed, or who are at risk for developmental delays due to certain biological and/or environmental factors.

Early Intervention services are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development. Services are selected in collaboration with families, using an Individualized Family Service Plan, and are provided under the supervision of a Massachusetts Department of Public Health-certified Early Intervention program in partnership with families. Services and staff reflect the cultural, linguistic, and ethnic composition of the state and of the families served. Programs must demonstrate a commitment to respond to the diversity of families in their communities. Early Intervention services focus on the family unit, recognizing

the crucial influence of the child's daily environment on his or her growth and development. Therefore, Early Intervention staff deliver services in the context of family daily routines, working in partnership with individuals present in the child's natural environment. Early Intervention staff support and encourage the families' use of and access to community-based resources that will continue to support and enhance the child's development.

These standards were developed to describe requirements of community Early Intervention programs, and are used as criteria by the Massachusetts Department of Public Health for Early Intervention program certification. These standards, and all Massachusetts DPH-certified Early Intervention programs, incorporate in their practice the following core values:

1. RESPECT

Recognizing that each group of people has its own unique culture, and honoring the values and ways of each family's neighborhood, community, extended family, and individual unit.

2. INDIVIDUALIZATION

Tailoring supports and services with each family to its own unique needs and circumstances.

3. FAMILY-CENTEREDNESS

Basing decisions with each family on its own values, priorities, and routines.

4. COMMUNITY

Realizing that each family exists in the context of a greater community, and fostering those communities as resources for supports and services.

5. TEAM COLLABORATION

Working as equal partners with each family and with the people and service systems in a family's life.

6. LIFE-LONG LEARNING

Viewing early intervention supports and services as a first step on a journey for each child, family, and provider.

II. DEFINITIONS

Caregiver As used in these standards, a caregiver is a person in whose care a child may be temporarily placed, including, but not limited to, non-custodial relatives, baby-sitters, child care providers, and nannies.

Co-treatment visit A co-treatment visit is either a home visit or a center-based individual visit with two or more Early Intervention Specialists of different disciplines present. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and approaches to treatment. One co-treatment of Early Intervention Specialists is allowed per month for an enrolled child. Consultative visits with specialty providers for children with low incidence conditions are not considered co-treatments.

Day As used in these standards, day means calendar days.

Due Process Due process refers to the regulations established by the Massachusetts Department of Public Health for community Early Intervention programs certified by the Department of Public Health with respect to notice of rights, informed consent, records and confidentiality, appeals and complaints.

Early Intervention Program An Early Intervention program is one that is formally certified by the Massachusetts Department of Public Health as a community Early Intervention program. It is in compliance with these standards set forth by the Massachusetts Department of Public Health.

Early Intervention Services

General Early Intervention Services are services that (1) are designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development; (2) are selected in collaboration

with the family in conformity with the Individualized Family Service Plan; and (3) are provided by qualified personnel working with an Early Intervention program.

Types of Services

(A) Home Visit A face-to-face meeting at the enrolled child's home or a setting outside of the Early Intervention program's primary (lead) site with the enrolled child, the enrolled child's parent, or both, and an Early Intervention Specialist for the purpose of furthering the child's developmental progress. A home visit is provided for a scheduled period of time not to exceed two hours.

(B) Center Individual Visit (CV01) A visit provided in conjunction with an **EI-only Child Group**, identified on the IFSP as a Center Individual Visit provided as part of an EI-only Child Group. This service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting. A center individual visit is provided for a scheduled period of time not to exceed two hours.

Center Individual Visit (CV02) A visit provided in conjunction with a community-based child group service **held at any DPH-approved site** and identified on the IFSP as a Center Individual Visit occurring within a Community Group setting. A center individual visit is provided for a scheduled period of time not to exceed two hours.

Center Individual Visit (CV03) A visit provided without child group participation and identified on the IFSP as a Center Individual Visit. This service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting. A center individual visit is provided for a scheduled period of time not to exceed two hours.

(C) Child Focused Group A face-to-face meeting at a community-based site of a group of enrolled children (2 or more), facilitated or co-facilitated by at least one certified Early Intervention Specialist (as defined in these

standards) for the purpose of furthering the enrolled child's developmental progress. Child focused groups are provided for a scheduled period of time from one to two-and-one half-hours not more than two times weekly. A child-focused group must be identified on the child's IFSP.

Child-focused groups may be provided in any of three types of settings: lead, shared or participatory, as defined in these standards. Each type of setting is subject to DPH approval, as defined in Section XI., E of these standards. Adult/child ratios for child-focused groups are as follows:

1) **Lead site**, where the Early Intervention program is responsible for administration of both the program and the physical facility.

a. Children under 18 months of age must be accompanied by a parent or caregiver (as defined in these standards) for any center-based activity at a lead site. Parents/caregivers must remain on site but are not required to remain in the group with the children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staff person (can include interns, volunteers, EI assistants, or EI associates) for every two children under 18 months. If only one EI staff person is present, it must be the EI Specialist who facilitates or co-facilitates the group.

b. Children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staff person for every three children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents/caregivers of community children are expected to attend the group then parents/caregivers of EI-enrolled children are also expected to attend. Attendance sheets must be maintained for all participants.

2) **Shared site**, where the Early Intervention program shares responsibility with a community site for program services but not for the administration of the physical facility.

a. EI-enrolled children under 18 months of age must be accompanied by a parent/caregiver for any center-based activity at a shared site. Parents/caregivers must remain on site but are not required to remain in the group with children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staffperson for every two EI-enrolled children under 18 months.

b. EI-enrolled children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staffperson for every three EI enrolled children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents/caregivers of community children are expected to attend the group then parents/caregivers of EI-enrolled children are also expected to attend. Attendance sheets must be maintained for all participants.

3) **Participatory site**, where Early Intervention staff and families join an ongoing activity in the community where the Early Intervention program does not have responsibility for either the program administration or the physical facility.

a. EI-enrolled children under 18 months of age must be accompanied by a parent/caregiver for any activity at a participatory site. Parents/caregivers must remain on site but are not required to remain in the group with children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staffperson for every two EI-enrolled children under 18 months.

b. EI-enrolled children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staffperson for every three EI-enrolled children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents of community children are expected to attend the

group then parents of EI-enrolled children are also expected to attend. Documentation of attendance may be requested of the site staff, and filed in the children's files with progress notes.

There are two types of Child Focused Groups**: (1) Community Child Group** and **(2) EI-Only Child Group**. Each type of group must follow the above ratios.

Community Child Group (CG02) is a group of two or more children designed to provide developmental opportunities for children ages birth to three, including children who are participating in group services as part of an Individualized Family Service Plan, and children who are not enrolled in Early Intervention. The purpose of the group is to enhance each child's development, and to provide opportunities for young children to come together. The Community Child Group supports the concept that Early Intervention services are most effective when provided in families' everyday routines and activities.

Community Child Groups are provided in locations where young children are welcome and typically spend time. Everyday places may include childcare settings, playgrounds, libraries, community centers, Early Intervention programs, or other neighborhood and community programs. This Child Group should be specified on the IFSP as a "Community Child Group."

EI-Only Child Group (CG01) A developmental group of two or more children where the only participants are children and families enrolled in EI. When a child participates in an EI-Only Child Group, the child's IFSP must include appropriate clinical justification as to why outcomes cannot be achieved in a natural setting, as well as a plan to move toward group services in a community setting. The justification and the plan need to be reviewed a minimum of every six months through the IFSP process. Child group services should be specified on the IFSP as EI-Only child Group.

(D) Parent-focused Group A face-to-face meeting of a group of enrolled children's **parents** with an Early Intervention Specialist for the purpose of support and guidance. A parent-focused group (s) is provided for a regularly scheduled period of time not to exceed two hours per week. If more than one parent of a child attends a group, the reimbursement for one of the parents (or both if no other insurance coverage) may be from the Department of Public Health.
Time-limited (one or more sessions), topic-specific parent educational groups may be provided as Parent-focused groups. These educational groups will have an evaluation component, reported in the program's annual report.
A group for other members of the enrolled child's family, including siblings, may be offered for not more than twelve sessions in a twelve-month period. These sessions will be based on a specific curriculum that addresses the impact of the developmental needs of the enrolled child on family members.

(E) Screening Screening consists of a face-to-face meeting of a referred child and caregiver with an Early Intervention Specialist to discuss a child's potential participation in Early Intervention.
Screening in Early Intervention may or may not include the administration of a developmental screening tool and is limited to two working hours. An initial visit that provides a family with an opportunity to discuss program participation can be considered a screening visit. Families may receive a screening visit by more than one Early Intervention program. Families are informed of their right to a full assessment at the screening visit.

(F) Assessment Assessment means the ongoing procedures used by appropriate qualified personnel throughout the child's eligibility to identify (1) the child's unique strengths and needs; and (2) the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child. Eligibility evaluations may take place as part of an assessment. When evaluation and assessment take place simultaneously, both eligibility and the strengths and needs of the child are determined by a multidisciplinary team. This

event is referred to as an evaluation and assessment. Assessment hours, including eligibility evaluation and IFSP development, are limited to ten billable hours per year.

Early Intervention Specialist An Early Intervention Specialist is an individual who meets the criteria specified in Section V., B of these standards and is certified by the Massachusetts Department of Public Health. The certification may be provisional, provisional with advanced standing, or full certification.

Eligible Children As used in these standards, eligible children means those children, birth to age three, who through a multidisciplined evaluation by a certified Early Intervention program are deemed eligible to receive Early Intervention services. Eligible children may receive EI services up to but not on their third birthday.

Eligibility evaluation An eligibility evaluation refers to procedures used by appropriately qualified personnel to determine a child's initial and continuing eligibility. The evaluation is performed at least annually except for those children determined eligible through clinical judgement. An eligibility evaluation may be part of a multidisciplinary assessment.

Individualized Family Service Plan (IFSP) An IFSP is a written plan for providing Early Intervention services to an eligible child and the child's family in accordance with federal regulations and the Massachusetts Department of Public Health Early Intervention Operational Standards, Section VII.

Intake Visit The intake visit is the initial face-to-face contact with the family and provides an opportunity for initial discussion with family members regarding potential participation in Early Intervention. An intake visit may be billed as a screening visit.

Low-incidence condition Low incidence refers to a diagnosis of blindness, visual impairment, deafness, hearing loss, deafblindness, autism, or Autism Spectrum Disorder (ASD). A child who has one or more of these conditions fits the criteria for services to children with low incidence conditions.

Multidisciplinary team A team consisting of two or more Early Intervention Specialists of different disciplines, as defined in Section V. of these standards.

Primary language Primary language means the language or mode of communication normally used by the parent of a child seeking or using services. If the parent has a vision or hearing loss, the mode of communication shall be that normally used by the parent, such as sign language, Braille, oral communication or other appropriate mode of communication.

Natural Settings Natural settings are those settings that are typical for children similar in age who have no disabilities.

Parent As used in these standards, parent means the biological/adoptive parent of the child, legal guardian, other person having legal custody of the child, relative or close friend with whom the child lives and who takes responsibility for the child's welfare, or a surrogate parent, but does not include any parent whose legal right to make educational decisions has been terminated.

Parental Consent This term means that (1) the parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's primary language or other mode of communication; (2) the parent understands and agrees in writing to the carrying out of the activity for which consent is sought and the consent describes that activity and lists the records (if any) that will be released and to whom; and (3) the parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

Service Coordination As used in these standards, service coordination means the activities carried out by a service coordinator to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the state's Early Intervention system.

Specialty Provider A specialty provider is a professional who is specifically trained and/or credentialed in working with children with low incidence conditions and their families.

Surrogate Parent A surrogate parent is an individual assigned by the Massachusetts Department of Public Health to represent the rights of an eligible child in the following circumstances: (1) when the Department, after reasonable efforts, is unable to identify or locate the parent, guardian or person acting as parent of the child; or (2) when the child is in the legal custody of a State agency and the natural parent's rights to participate in educational decision making have been terminated. In this case, a foster parent will be designated as surrogate unless he or she indicates or demonstrates an unwillingness or inability to serve as surrogate.

Written informed consent This term means a form or other written record which serves as evidence that the explanation required for informed consent has been provided. The parent's signature shall serve as documentation that the parent understands and agrees to the proposed terms and activities.

III. Eligibility for Early Intervention Services

A. Determination of Eligibility

Certified Early Intervention programs determine eligibility for Early Intervention services through an eligibility evaluation performed by a multidisciplinary team, exercising sound clinical judgment, and using a developmental evaluation tool approved by the Massachusetts Department of Public Health.

B. Categories and Criteria of Eligibility

There are two categories of eligibility for early intervention services.

1. Children with Established Risk or Established Developmental Delays :

   This category includes (1) children whose early development is influenced by diagnosed medical disorders of known etiology bearing relatively well known expectations for developmental outcome within varying ranges of developmental delay and (2) children who, during the infancy period, or more commonly in the second year of life, begin to manifest developmental delays or deviations, often of unknown etiology.

   Criteria

   (1) The child has a known disabling physical or mental condition including but not limited to any of these diagnoses:

   - chromosomal abnormality
   - neurological condition
   - metabolic disorder
   - visual impairments not corrected by medical intervention or prosthesis, or
   - permanent hearing loss of any degree

   or

   (2) The child exhibits a delay* in one or more areas of development, including cognitive development, physical development including vision

and hearing, communication development, social or emotional development, or adaptive development

or

(3) The child has questionable quality of developmental skills and functioning based on the clinical judgment of a multidisciplinary team. A child found eligible based on clinical judgment can receive services for up to 6 months. For services to continue after this period, eligibility must be determined based on diagnosis, developmental delay or risk factors.

***Guideline: Developmental delay by age and months of delay**

AGE	**DELAY**
6 months or less	**1.5 months**
7-12 months	**3 months**
13-18 months	**4 months**
19-36 months	**6 months**

2. Children at Risk for Developmental Delays or Disorders: This category includes

(1) children with a history of prenatal, perinatal, neonatal, or early life events suggestive of biological insults to the developing central nervous system which, either singularly or collectively, increase the probability of later atypical development and (2) children who are biologically sound but whose early life experience, including maternal and family care, health care, nutrition, opportunities for expression of adaptive behaviors, and patterns of physical and social stimulation are sufficiently limiting to the extent that they impart high probability for delayed development.

Criteria

Four or more of the following risk factors are present:

CHILD CHARACTERISTICS

- Birthweight is less than 1200 grams (2 pounds 10½ ounces)
- Gestational age is less than 32 weeks
- NICU admission is more than 5 days
- Apgar score is less than 5 @ 5 minutes
- Total hospital stay is more than 25 days in 6 months
- Diagnosis of Intrauterine Growth Retardation (IUGR) or Small for Gestational Age (SGA)
- Weight for age, or weight for height, is below the 5th percentile; weight for age dropped more than 2 major centiles in 3 months in a child who is under 12 months of age or has dropped more than 2 major centiles in 6 months in a child who is 12 to 24 months of age.
- Chronic feeding difficulties
- Insecure attachment/interactional difficulties
- Blood lead levels measured at 15 µg/dl (micrograms per deciliter) or more.
- Suspected Central Nervous System abnormality
- Multiple trauma or losses

FAMILY CHARACTERISTICS

- Maternal age at child's birth is less than 17 years or maternal history of 3 or more births before age 20
- Maternal education is less than or equal to 10 years
- Parental chronic illness or disability affecting caregiving ability
- Family lacking social supports
- Inadequate food, shelter, or clothing
- Open or confirmed protective service investigation
- Substance abuse in the home
- Domestic violence in the home.

Appendix A of these standards provides explanations of eligibility criteria.

IV. Service Area

A. Local Service Area

An Early Intervention program serves all cities and towns within its service area as approved by the Department of Public Health. If more than one EI program shares a service area or a family is referred to an EI program outside the service area of the family's residence, upon referral to a program, parents are notified of the names of the other programs serving that service area and have the opportunity to talk with the other programs before having an eligibility evaluation. At the initial visit each family will be provided information about the *Massachusetts Early Intervention Program Guide* which contains the statewide listings of all Early Intervention programs.

B. Options

Parents are made aware that they may only enroll in one Early Intervention program. Once the family makes the choice, the program has 45 days to evaluate the child, determine eligibility and hold a meeting to discuss the Individualized Family Service Plan (IFSP). Parents are also informed that investigating other programs may prolong the time it takes to complete the IFSP process. This discussion is documented in the intake file.

C. Out of Catchment Services

Programs are responsible for providing individualized services to families as outlined in the IFSP. Occasionally this means that services may be provided outside of the service area in which the family resides.

The Regional Early Intervention Specialist must be notified in writing of families not residing in the program's service area being served by the program. (See Out of Catchment Notification Form in the *Massachusetts Early Intervention Services Policy Book*).

V. Service Providers and Roles

A. Professional Certification

All professional staff members who will be providing direct service to children and families, employed directly or indirectly by an Early Intervention program (including salaried, contract/fee for services, or consultant/subcontract), are certified as Early Intervention Specialists by the Massachusetts Department of Public Health prior to billing for Early Intervention services.

Primary program administrators, usually Program Director or Program Coordinator, meet the credentialing requirements for one of the disciplines listed in Section B below. The primary program administrator is required to apply for Early Intervention Program Director certification within three years of hire to that position. Further description may be found in Section XII, Program Administration, of these standards.

Certification for Early Intervention Specialists may be:

a. Provisional (granted through the Department of Public Health to staff who meet entry level requirements and work in EI)
b. Provisional with advanced standing (granted through the Department of Public Health to graduates of DPH-approved higher education programs in early intervention after satisfactory review of completed application and transcripts) or
c. Full certification (granted through the Department of Public Health after satisfactory completion of the EI certification process. Application must be completed by the end of 3 years of employment at an MDPH-certified EI program, working at a minimum of 20 hours per week. Also granted to

graduates of DPH-approved higher education programs upon completion of 1440 hours of employment at an MDPH-certified EI program.)

B. Early Intervention Credentials

MDPH-certified EI programs must demonstrate a commitment to respond to the diversity of families in their communities. Staff should, to the extent possible, reflect the cultural, ethnic and linguistic background of families served.
The following are the minimum credentials for entry level provisional certification as an Early Intervention Specialist:

1. *As Developmental Specialist:*
    a) A bachelor's degree from an accredited institution with a major or concentration in infants and toddlers (includes early intervention and early childhood education), and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

    b) A bachelor's degree from an accredited institution with a major or concentration in child development or child studies, and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

    c) A bachelor's degree from an accredited institution with a major or concentration in education or special education, and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

    d) A bachelor's degree from an accredited institution, with at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

For a, b, c, and d transcripts of degree work or subsequent transcripts must reflect successful completion of at least 4 approved three-credit courses that focus on infants, toddlers, and families.

2. *In Nursing:* Current licensure as a registered nurse by the Massachusetts Board of Registration, Division of Professional Licensure, with either:

(a) A bachelor's degree in nursing from an accredited program, or

(b) An associate degree or diploma in nursing from an accredited institution and at least two years of experience in community-based services for infants, toddlers and their families.

3. *In Occupational Therapy*: Current licensure as an Occupational Therapist by the Massachusetts Board of Registration of Allied Health Professions.
4. *In Physical Therapy*: Current licensure as a Physical Therapist by the Massachusetts Board of Registration of Allied Health Professions.
5. *In Social Work*: Current licensure as a Licensed Clinical Social Worker (LCSW) or as a Licensed Independent Clinical Social Worker (LICSW) by the Massachusetts Registry of Social Work.
6. *In Psychology:* A master's degree from an accredited institution in
    (a) counseling psychology
    (b) clinical psychology
    (c) developmental psychology
    (d) educational psychology

    or

    (e) Current licensure as a Licensed Mental Health Counselor (LMHC) by the Massachusetts Board of Allied Mental Health and Human Services Professions

    (f) Current licensure as a Licensed Marriage and Family Therapist (LMFT) by the Massachusetts Board of Allied Mental Health and Human Services Professions
7. *In Speech and Language Pathology:* (a) Current licensure by the Massachusetts Board of Registration in Speech-Language Pathology and Audiology and a Certificate of Clinical Competence (CCC) granted by the

American Speech, Language and Hearing Association or (b) currently in clinical fellowship year prior to being granted a CCC.

Specialty Provider: Early Intervention services may also be provided by qualified personnel who bring specific expertise necessary for working with populations including, but not limited to, children with low incidence conditions and their families. Qualification is based on the highest requirements in the State applicable to the profession or discipline in which a person is providing early intervention services. To provide direct service to children and families, Specialty Providers are granted limited provisional certification as Early Intervention Specialists.

- The following are the minimum credentials for entry level provisional certification with advanced standing as an Early Intervention Specialist:

1. Graduation from a DPH-approved higher education Early Intervention training program. Upon graduation, Provisional Certification with Advanced Standing (PCAS) will be granted for up to three years.

- The following are the minimum credentials for full certification as a certified Early Intervention Specialist:

1. Submission of a portfolio documenting competencies as an Early Intervention Specialist within 3 years of employment (working at least 20 hours per week) in a MDPH-certified Early Intervention program, for staff with provisional certification, or
2. Completion of 1440 hours of supervised experience in a MDPH-certified Early Intervention program, for staff with provisional certification with advanced standing.

C. Related Credentials:

1. Early Intervention Assistant

   Early Intervention Assistant is an entry-level position with an educational requirement of a high school diploma or equivalent. The duties of these individuals are generally (1) organizational in nature, e.g. purchase of

materials or coordination of transportation; (2) related to child-focused groups, such as classroom preparation and/or (3) supervised participation in activities with children and families.

2. Early Intervention Associate

The Early Intervention Associate has a minimum educational requirement of a high school diploma or equivalent with additional credentialing working with infants and toddlers. An EI Associate may have any of the following credentials:

(1) Completion of an associate degree in Early Childhood Education
(2) Credentialing as a Child Development Associate
(3) Registration and licensure in Massachusetts as a Certified Occupational Therapy Assistant or a Physical Therapy Assistant
(4) Designation as a Lead Infant/Toddler Teacher by Office of Child Care Services
(5) Licensure in Massachusetts as a Licensed Practical Nurse
(6) Parent of a child enrolled for at least one year in a DPH-certified Early Intervention program

The scope of participation of an Early Intervention Associate includes work with children and families, under close and regular supervision and in accordance with the appropriate guidelines of practice for specific disciplines. Duties may include direct services to a child and family, participation in IFSP development, service coordination, program outreach, and intakes, all under the supervision of an Early Intervention Specialist.

Early Intervention Assistants and Early Intervention Associates do not bill for Early Intervention services.

D. Early Intervention Program Core Team

1. An Early Intervention Program has a minimum of three core team members, each of whom must work at least 30 hours per week. The core team is comprised of a Developmental Specialist (a through c) and two other professionals representing different disciplines as defined in B, 2 – 7 of this section. In addition to the core team, an Early Intervention program will have a full time director/coordinator.

2. If at any time following the initial program certification, the staffing of the program does not meet the requirements for a core team, the program director will notify the Regional Early Intervention Specialist in writing of the absence of a core team. The program will be given sixty days from the first day of noncompliance to regain compliance of this requirement. Families enrolled in the program will be notified in writing of the absence of a core team for the timeframe this situation exists and of the options available to them for comprehensive Early Intervention services. Families will also be given a copy of Family Rights in Early Intervention at this time. A copy of the written notice to families will be submitted to the Regional Early Intervention Specialist for review before distribution and a copy of the notification filed in each child's record. If a core team is not in place at the end of the sixty-day period, a program certification review will take place.

VI. Entry Into Program

A. Child Find

Child Find is a series of activities in the community that are organized to locate children and families who are potentially eligible for Early Intervention services and may be part of the EI program's community education activities. These activities may be initiated and carried out, with written parental permission, by EI program staff alone, in conjunction with staff of other agencies, or by other agencies without Early Intervention program involvement. If children and families are considered potentially eligible for EI services, on the basis of screening or less formalized developmental review, a referral to the EI program will be made according to the procedures described below.

B. Referral

1. EI programs accept referrals from all sources. If the family is not the referral source, they must be informed prior to referral. A face-to-face or telephone response to the family from the EI program is made within 10 working days following the initial referral. Attempts to contact families are documented in the child's record.
2. The EI program schedules a visit with the family preceded by written notification of what the visit will involve. Written parental consent is obtained at the first face-to-face contact in order for the visit to proceed.
3. Once the visit has been scheduled, the EI program shall assign a service coordinator to be available to the family during the eligibility determination and IFSP process. Within 45 days after receiving a referral, the Early Intervention program will complete the evaluation and assessment activities and, if the child is found eligible for Early Intervention services, hold a meeting to complete the IFSP process.

C. Screening/Intake Process

1. The initial face-to-face contact with the family provides an opportunity for discussion with family members regarding potential participation in Early Intervention. The visit is scheduled in response to family need with regard to time and location. Often the child's medical and developmental histories are discussed, an overview of Early Intervention is given to the family, and plans are made for the evaluation and assessment process. This visit may be billed as a screening visit. Families are informed of their right to a full assessment at the screening visit.
2. The parent is given the Massachusetts Department of Public Health Notice of Family Rights. The program will ensure that the parent understands the notice, that there is written evidence that these requirements have been met, and that the parent has been given the opportunity to discuss the contents of the notice and have questions answered.

D. Eligibility Evaluation

1. Eligibility evaluation means the procedures used by qualified personnel to determine a child's initial and continuing eligibility in Early Intervention. Eligibility evaluations are performed by certified Early Intervention programs.
2. Written parental consent is obtained prior to an eligibility evaluation.
3. As a part of this process, an evaluation of the child's development is to be made by a multidisciplinary team using a DPH-approved developmental evaluation tool. Functioning in each of the following areas is evaluated to determine eligibility:
    a. Cognitive development
    b. Physical development (gross and fine motor), including vision, hearing, and health status
    c. Communication development, including expressive and receptive language development

d. Social and emotional development

e. Adaptive development/self help

4. Eligibility evaluation further consists of a determination of family and child risk factors to document eligibility as described in Section III B.2. of these standards.
5. The eligibility evaluation process is culturally and linguistically appropriate for the child and family.
6. The disciplines represented on the multidisciplinary evaluation team are determined by the developmental areas of concern for the child.
7. When eligibility evaluation and assessment take place simultaneously, both eligibility and the strengths and needs of the child are determined by a multidisciplinary team. This event is referred to as an evaluation and assessment.
8. The primary referral source is notified in writing of the outcome of the eligibility evaluation with family consent.

E. Assessment

1. Assessment consists of those on-going procedures used by appropriate qualified personnel throughout the period of a child's eligibility for services to identify (1) the child's unique strengths and needs and the services appropriate to meet those needs; and (2) the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler.
2. The assessment emphasizes the collaborative process among Early Intervention personnel, the family, and other agencies and providers. Logistics should be primarily responsive to family and child needs and preferences regarding time, place and other such factors. Families will be given prior written notice of assessments. The notice will include the voluntary nature of consent.

3. A review of available records related to the child's current health status and medical history is to be completed as part of the assessment.
4. An assessment of family resources, priorities, and concerns is family-directed and designed to determine ways to enhance the development of the child. Any assessment of a family's need for support or services is voluntary in nature, and based on information provided by the family through personal interviews conducted by personnel trained in appropriate methods and procedures.

VII. Individualized Family Service Plan Development

A. An Individualized Family Service Plan (IFSP) is a working document produced collaboratively by program staff and family members that contains the agreed upon Early Intervention services for an eligible child and family. Based on multidisciplinary assessment, the plan includes services necessary to enhance the development of an eligible child, and the capacity of the family to meet the child's needs. The plan is written in the family's primary or chosen language, unless it is clearly not feasible to do so. An English translation of the child's developmental profile and the service delivery plan is available at the program site for coordination and program monitoring purposes. All certified Early Intervention programs use the IFSP form approved by the Massachusetts Department of Public Health.

B. The contents of the IFSP are fully explained to the child's family and informed written consent from the parents is obtained prior to the provision of Early Intervention services described in the plan. If the parents do not provide consent with respect to a particular EI service or withdraw consent after first providing it, that service may not be provided. ***This action will not jeopardize the provision of other Early Intervention services.*** The EI services to which parental consent is obtained must be provided.

C. An IFSP meeting is held with eligible families within forty-five days of referral. An IFSP meeting is convened at a time and place mutually convenient for the family and team members for the purpose of developing the plan. The Department of Public Health strongly discourages the practice of screening, evaluation and IFSP development on the same day. Written confirmation of IFSP meeting arrangements is sent to participants early enough to ensure attendance. Each initial and subsequent IFSP meeting, following an eligibility evaluation, includes the following participants:

1. The parent or parents of the child (or person legally designated in this function)
2. The individual designated to be the service coordinator
3. Another person or persons directly involved in conducting the evaluation and assessment
4. Other family or team members as requested by the parent if feasible to do so *
5. An advocate or other non-family member, if the parent requests that the person participate *
6. As appropriate, persons who will be providing services to the child and/or family

* If a person the parent wishes to have involved in the planning meeting is unable to attend, arrangements are made for the person's involvement through other means, including:

1. Participating in a telephone conference call
2. Having a knowledgeable designate attend the meeting
3. Making pertinent records available at the meeting

D. The plan is based on the results of multidisciplinary team assessment, and includes the following:

1. A statement of the child's present level of physical development (including vision, hearing, and health status), cognitive development, communication development, social and emotional development, and self-help/adaptive development. These statements are based on professionally acceptable objective criteria.
2. A statement of the child's strengths and needs, including documentation of the techniques used to determine the strengths and needs
3. Information regarding the child's and family's daily routines/activities
4. A statement of the family's strengths, concerns, priorities and resources related to enhancing the development of the child, if the family so desires

5. A statement of the outcomes identified by the family expected to be achieved for the child and family. The team, which includes the family, identifies the strategies to be focused on which include the criteria, procedures and timelines used to determine (1) the degree to which progress toward achieving the outcomes is being made; and (2) whether modifications or revisions of the outcomes or services are necessary
6. A statement of the Early Intervention services necessary to meet the unique needs of the child and family to achieve the outcomes, including transportation plans, service frequency (how often), duration (how long), and the location (where occurring) of sessions; whether these are individual or group services (method), and the EI staff member(s) responsible
7. A statement of the natural settings in which Early Intervention will be provided, including justification of the extent to which the services will not be provided in a natural environment
8. A statement of medical services, specialty providers and other community resources and services which are or will be involved with the child and family, with parental consent, including the Early Intervention program's plan for coordination with these resources
9. The time period covered by the plan, including the projected date of initiation of services as soon as possible after the IFSP meeting. Parents are kept informed of all efforts to secure services and documentation should reflect the search for services and methods used to obtain them. The date of parental signature shall constitute the initiation of the plan, with an expiration date not more than one year from initial parental signature.
10. The plan for service coordination agreed upon with the family, including the individual responsible for ensuring the coordination and implementation of the IFSP. This individual should be from the profession most relevant to the child or family's needs.
11. A statement of transition procedures

12. At least six months before anticipated discharge, the plan for transition either to services provided by the Local Educational Agency (LEA) or to other appropriate settings. This process follows the steps outlined in the Interagency Policy on Early Childhood Transitions. See Appendix B of these standards.

The IFSP must identify medical and other community services and resources that the child needs but that are not required under Part C of IDEA (Individuals with Disabilities Education Act) or M.G.L. 111G. The IFSP should also identify the steps that will be undertaken to secure those services through public or private resources.

E. At least every six months or whenever the family or another IFSP team member requests, the IFSP is reviewed by family and other team members. This review is to take place in a meeting or other means acceptable to the family and other participants. The review includes a determination of the degree to which progress is being made toward achieving agreed upon outcomes, appropriateness of services being delivered and/or possible changes in outcomes or service plan. These are documented on the corresponding page of the IFSP.

F. Modification of the IFSP may occur at any time. Modification may include changes in

- the outcomes
- specific Early Intervention services
- service frequency or location. Parental consent to any change is documented in writing on the IFSP before a change is made.
- information the parent chooses to have amended for any reason

G. At least annually, a multidisciplinary eligibility evaluation/assessment is performed and a meeting is held to revise the IFSP as appropriate, based on eligibility evaluation/assessment results.

H. Parents must be provided with a copy of their family's IFSP, including each revision.

VIII. Early Intervention Services

A. Children and families receive individualized services, in accordance with the outcomes identified in the IFSP. A range of options, provided at lead, shared or participatory sites, including home visits, center-based individual visits, parent/child groups, child-focused groups, parent-focused groups and services of specialty providers is available to all families. Intervention is designed to include the child, staff member(s) and parent or designated caregiver. The parent is encouraged to participate in services. If family circumstances preclude such participation, this is documented in the child's record and alternative communication strategies developed.

B. Services are available on a twelve-month basis. Any scheduled interruptions of any service for more than three (3) consecutive weeks are discussed and approved by the family, and documented on the Individualized Family Service Plan. Varying family needs and cultural differences are respected in the provision of Early Intervention services, and programs are responsive to family schedules if at all feasible.

C. Services are provided in the natural settings for the child, as determined through the IFSP process. Natural settings may include the child's home, childcare centers, family childcare homes, and other community settings.

D. The individual who will act as service coordinator is determined during the IFSP process. Service coordinator functions include the following:

1. Identify and negotiate service coordination functions with the family
2. Explain the IFSP process and procedural safeguards, and facilitate and participate in its development, review and evaluation
3. Collaborate with the family in identifying their strengths, concerns, priorities and resources

4. Facilitate the timely delivery of services
5. Coordinate and monitor evaluations, assessments, and service delivery, including the need for specialized assessments
6. Provide information on parenting issues and community resources
7. Educate and/or support the family in advocating for their rights and needs, including the availability of advocacy
8. Coordinate services with medical and health providers, with family consent
9. Refer to other case management systems when appropriate and with written parental consent
10. Assist in developing a transition plan
11. Refer the family to specialty providers as appropriate

IX. Transition and Discharge

A. The program will discharge a child and family from Early Intervention services when:

1. The child reaches his or her third birthday
2. The child and family no longer meet eligibility criteria
3. The family withdraws consent for all services. This is documented in the child's record.
4. The program is unable to contact/locate the child and family after reasonable attempts to contact and after a written notice has been sent to the family. This is documented in the child's record.
5. The child dies. The program may provide support to the family during the initial grieving process, with a waiver from the Department of Public Health.

B. The discharge date of all children is on or before the child's third birthday. Eligible children may receive services up to but not on their third birthday. To allow for collaboration and follow-up to occur, one visit within 90 days of the discharge date is allowed by the Department of Public Health. This visit may be a visit to the family, Local Education Agency (LEA) team meeting, or to the receiving program. This visit is recorded as a home visit.

C. Transition Plans must be developed for all children**.** Transition is the process by which a child and family are assisted in preparing for discharge from Early Intervention services. All information shared outside of the team requires parental consent. Transition plans are developed:

1. When the family moves from one Early Intervention program to another. Staff from the sending program and the family determine the steps to be taken to facilitate a smooth transition, and the individual(s) responsible for

each task. Staff from the receiving program, with parental consent, review the existing IFSP, including the assessment history**,** with the family and complete any agreed upon changes within forty-five days of the family's relocation. Disruptions of Early Intervention services to the child and family must be minimized, as much as possible.

2. At least six months before the child's 3rd birthday, a referral must be made to the LEA for possible services in accordance with MA Special Education Regulations (603 CMR 28.00, section 2804 (1) (d). The Interagency Policy on Early Childhood Transitions (found in Appendix B of these standards) includes the guidance for the planning process which will take place when the child is transitioning to special education services. At least 90 days before the child's 3rd birthday, with parental consent, the Early Intervention program convenes a meeting with the family, a representative from the LEA and the Early Intervention program staff**.** The purpose of this meeting is to review the child's service history, discuss possible program options with the LEA, and establish a transition plan. With parental consent, information about the child, including evaluation and assessment information and relevant information from the IFSP is sent to the LEA or other designated service provider or program.
3. When a child is determined ineligible for or has not been referred to preschool services under MA Special Education Regulations. With parental approval, the EI program makes reasonable efforts to convene a conference that includes the family and providers of other appropriate services for children (e.g., child care, Head Start, MA Family Networks, Community Partnerships for Children) to discuss appropriate services for which the child may be eligible.
4. When the child is under three years of age and either no longer meets the eligibility criteria for Early Intervention or the family chooses to terminate EI services. The reason for transition must be clearly documented in the child's record. Transition plans for children who are no longer eligible for EI services are in effect for up to forty-five days following the

determination of ineligibility, at which time the child is discharged from the EI program. There is documentation in the child's record of mutual agreement of determination of ineligibility.

X. Family Participation

A. Early Intervention in Massachusetts is a family-centered system. EI services are provided in a collaborative manner with families and EI service providers working as partners. Family members are encouraged to be active participants in every component of the Early Intervention service system. On an individual level family members are involved in determining and participating in services for their child and family. On the program level, families are encouraged to advise and participate in the development and monitoring of policies, procedures and practices. Family members may choose to participate in these advisory functions as a group or as individuals.

B. To ensure comprehensive family participation, all members of the EI service team share responsibility for providing an environment in which such participation can occur. Early Intervention programs provide multiple and varied opportunities for family participation that ensure responsiveness to the diverse needs and interests of the families in the service population and enhance the collaborative nature of service delivery.

C. In order to support family participation throughout the Early Intervention system, a program shall be able to demonstrate its efforts in the following activities:

1. Ensure that families understand the core values (see Section I of these standards) and range of individualized options, service delivery and supports
2. Establish a mechanism to share information about services, supports and opportunities with all families on a regular basis, not only on the first visit
3. Develop ongoing mechanisms which seek input from a diverse and representative number of families and incorporate the mechanisms into its policy and procedure/operations manual as part of its administrative organizational plan

4. Ensure that all families are aware of the existence of and have access to the program's policy/procedure/operations manual. The program will assume the cost of copying specific policies on request.
5. Ensure that a diverse and representative number of families are involved in the annual self evaluation which should include areas such as:
    a. Feedback on staff performance
    b. Evaluation of program services
    c. Review of the IFSP process
    d. Approaches to family participation
    e. Review of transition procedures
6. Programs will respond to written suggestions and evaluations offered by families within 7 days. Families who have difficulty in producing written documentation may request assistance.
7. Families and program staff will work together to develop an action plan to address concerns.
8. Include a diverse and representative number of families in any ongoing program development initiatives, such as the development of goals and objectives for the annual plan, service delivery task groups, modifications/updates to the policies and procedures, etc.
9. Develop mechanisms to share information about the EI statewide system and opportunities for parent participation including but not limited to the following:
    - making the Parent Leadership Project Resources Manual available to families
    - distributing *Parent Perspective* newsletter during home visits
    - inviting a parent to accompany EI staff to an ICC (Interagency Coordinating Council) related activity
    - sponsoring a parent to attend the MEIC (Massachusetts Early Intervention Consortium) Conference
    - informing families of statewide trainings
    - encouraging family participation on working committees

D. To assist in the above efforts, the program shall:

1. Designate an EI staff member to facilitate the involvement of a diverse and representative number of families and serve as a link between the staff and families
2. Cover reasonable administrative expenses such as copying and distribution of information requested by families
3. Recruit and support a parent currently receiving EI services to be the contact person for the EI Parent Leadership Project; this parent contact will share information among the Parent Leadership Project, program staff and families enrolled in the program.
4. Notify the Parent Leadership Project of the names of both the designated EI staff member and the current parent contact by calling 1-877-35-EI-PLP.
5. Invite the regional Parent Leadership Project Coordinator to attend at least one EI staff meeting annually.

E. For the purpose of meeting the diverse needs and interests of families in the program, family members enrolled in Early Intervention programs may choose to join together in a formal group, called a PAC (Parent Advisory Council), or may be involved in other ways as outlined in the Parent Leadership Project Resources Manual. Those needs and interests might include performing an advisory role with the program, establishing friendships with other families in the program, providing mutual support, facilitating networking, sharing information, and fundraising.

F. If a program has a PAC that chooses to play an advisory role, the program will still ensure that all families regardless of affiliation with the PAC are encouraged to be involved in the advisory activities listed above. If a program does not have a PAC, the program will ensure that families are informed that they have the option to form one. Information and support is available through the Parent Leadership Project (PLP).

G. If a program has a PAC, the program has the responsibility to:

1. Ensure information regarding the PAC's availability and activities is communicated to all enrolled families
2. Encourage activities which are responsive to the cultural and linguistic diversity of the program
3. Invite participation in the advisory functions outlined above.

H. The program provides support and assistance to families for developing and maintaining a PAC, such as:

1. Covering reasonable administrative expenses such as copying and distribution of information to families about the PAC and its activities
2. Copying and postage expenses for a PAC newsletter (if PAC members publish one)
3. Assisting family members to problem solve solutions to barriers to participation
4. Assisting with access to and the use of funds raised by the PAC
5. Designating an EI staff member who will be a link between the staff and the PAC

XI. Health and Safety

A. Health Care Consultant

The Early Intervention program has either a physician or registered nurse with pediatric or family health training and/or experience, as the program's health care consultant. The consultant assists in the development of the program's health care policy and approves and reviews the policy at least every two years. The consultant approves the first aid training for the staff, is available for consultation as needed, and approves any changes in the health care policy.

B. Health Care Policies

The program has written health care policies and procedures that protect the health and welfare of children, staff and families. All staff members are trained in such procedures and families receive copies of appropriate policies and procedures as requested. The written health care policy includes, but is not limited to, the following plans and/or procedures:

1. A plan for the management of infectious diseases. The plan includes:
    a. Criteria regarding signs or symptoms of illness which will determine whether a child, or staff member, will be included or excluded from activities
    b. Policies for when a child or staff member who has been excluded from activities may return
    c. Policies regarding the care of mildly ill children in attendance at a non-home-based activity including special precautions to be required for the following types of infectious diseases: gastro-intestinal, respiratory and skin or direct contact infections, until the child can be taken home or suitably cared for elsewhere
    d. Procedures for notifying parents when any communicable disease, such as measles or salmonella, has been introduced to the group

2. A plan for infection control. Procedures are written to include:
   a. directions for proper hand washing techniques
   b. instructions on the care of toys and equipment
3. A plan for the control of diseases spread by blood products and body fluids. Procedures are written to include:
   a. Universal precautions, including the requirement that staff use single-use latex-safe gloves when they are in contact with bodily fluids and that contaminated materials are cleaned or disposed of properly. (See Appendix C of these standards for Infectious Disease Control and Sanitation Requirements.)
   b. Annual training in blood-borne diseases including hepatitis B, C and HIV
   c. An exposure control plan
   d. Staff are offered a hepatitis B vaccine series at the time of hire
4. A procedure for reporting suspected child abuse or neglect to the Department of Social Services. The procedure includes assurances that:
   a. As mandated reporters all staff will report suspected child abuse or neglect to the Department of Social Services pursuant to M.G.L. c. 119 § 51A, or to the program's director or designee
   b. The program director or designee will immediately report suspected abuse or neglect to the Department of Social Services pursuant to M.G.L. c. 119 § 51A
   c. The program director or designee will notify the Department of Public Health, Early Intervention Services, immediately after filing a 51A report, or learning that a 51A report has been filed, alleging abuse or neglect of a child while in the care of the program or during a program related activity.
   d. The program develops and maintains written procedures for addressing any suspected incident of child abuse or neglect that includes but is not limited to ensuring that an allegedly abusive or neglectful staff member does not work directly with children until

the Department of Social Services investigation is completed or for such a time as the Department of Public Health requires.

C. Staff Requirements

1. Within the first six months of hire, all direct care staff obtains and maintains annual certification in CPR that specifically addresses infants and toddlers. The CPR curriculum includes the management of a blocked airway and rescue breathing. Staff must also obtain and maintain certification in pediatric first aid. The curriculum for first aid includes treatment for seizures and burns in addition to basic first aid training.
2. Prior to the initiation of any direct contact with families, new staff, regularly scheduled volunteers and student interns must present to the program director evidence of:
   a. A physical examination within one year prior to employment. The physical examination is valid for two years from the examination date and will be repeated every two years thereafter.
   b. Immunity for measles, mumps, rubella and chicken pox in accordance with MDPH regulations (See Appendix C of these standards.) Such evidence is not required of any person who states in writing that vaccination or immunization conflicts with his/her sincere religious beliefs, or if it is medically contra-indicated.
   c. Negative Mantoux TB test in accordance with current Department of Public Health regulations (See Appendix C of these standards.)
   d. Statement of physical limitations in working with children.
3. A CORI evaluation is completed on, and documented in the personnel file, of each person with the potential for unsupervised contact with children in accordance with current DPH requirements 105 CMR 950.: Criminal Offender Record Information Checks. (See CORI information in the *Massachusetts Early Intervention Services Policy Book*.)

D. Staff Health and Safety

1. The program provides for the reasonable safety of staff while providing services. This may include recommendations to staff regarding phoning families before visits, providing staff in-service training on safety issues.
2. The program provides updated information to staff regarding communicable diseases, preventive health policies, and environmental health risks including second hand smoke.
3. The program provides a copy of the Health and Safety section of these standards at annual staff trainings on health and safety issues.

E. Community Based Program Policies

Early Intervention services, not including those services provided in children's homes, are provided in settings that are safe, that support the optimal development of infants and toddlers, and that are conducive to community collaboration. Such settings are welcoming to young children and their families, and are often part of a naturally occurring family routine. It is critical that settings where young children spend time be carefully evaluated to ensure the health and safety of children, staff, and families participating in EI activities. EI services in community locations generally fall under the following three categories:

1) Lead site: a location where the EI program is primarily responsible for administration of both the program and the physical facility.
2) Shared site: a location where the EI program shares responsibility with a community site for program services, but not for the administration of the physical plant.
3) Participatory site: a location where EI program staff and families join an on-going activity in the community where the EI program does not have responsibility for either the program administration or the physical facility.

All EI programs, regardless of where activities take place, must have the following information readily available:

a. The current DPH Early Intervention program certification and Office of Child Care Services (OCCS) license when appropriate. The program must be licensed by OCCS if it meets the OCCS requirements in Section 102 CMR 7.03. If the program does not meet these requirements and does not have an OCCS license, an Early Intervention Program Facility checklist must be completed by DPH for any site where non-home based services are provided. It is the program's responsibility to notify OCCS in the event their status changes and licensing is required. For a lead site, the Early Intervention Program Facility Checklist must be completed. For a shared or participatory site, the Community Group Facility Approval Form must be completed when caregivers will not be present. (Both forms are found in Appendix C of these standards.)

b. The name, and telephone number of the health care consultant; the telephone number of the fire department, police department, Poison Control Center, ambulance service, nearest emergency health care facility, DPH central and regional offices, telephone number and address of the program, including the location of the program in the facility. This information shall be immediately visible at each telephone.

c. Location of the health care policy and first aid kit.

d. Updated allergy and/or other emergency medical information for each child.

e. Emergency preparedness plan.

f. Evacuation procedures next to each exit.

g. Diapering and toileting procedures.

h. Weekly snack menu. (Not required if provided by individual parent for his/her own child.)

i. Current activity schedule.

j. Behavior management policy.

2. EI staff obtain or have access to information from parents regarding:
    a. The child's daily schedule, developmental history, sleeping and play habits, favorite toys, accustomed mode of reassurance and comfort
    b. Procedures for toilet training of the child, if appropriate
    c. The child's eating schedule and eating preferences, where appropriate, including handling, preparation and feeding for unique dietary needs
3. The program has written procedures in place to be followed by EI staff to communicate with parents on a regular basis.
4. The program has written procedures to be followed in case of illness or emergency. These procedures include method of transportation and notification of parents, as well as procedures when parent(s) cannot be reached. In addition programs shall obtain:
    a. Written parental consents for emergency first aid and transportation to a specific hospital in emergencies
    b. Written parental consent specifying any person authorized to take the child from the program or receive the child at the end of an activity
    c. If parent not present, parental permission must be obtained for child to participate in activities at various community locations (e.g. library, playground)
    d. Additional parental consent for any field trips not on list above
5. The program maintains adequate first aid supplies and has a procedure for the use, storage and transportation of first aid supplies. A portable first aid kit must accompany staff on all non-home based activities. (See Appendix C of these standards for information regarding first aid kits).

6. The program has an injury reporting policy that includes, but is not limited to:

a. An injury report that includes the name of child, date, time and location of accident or injury, description of injury and how it occurred, name(s) of witness(es), name(s) of person(s) who administered first aid or medical care and first aid or medical care required (See sample injury report from OCCS in Appendix C of these standards.)

b. The policy for informing parents, in writing, within 24 hours, of any first aid administered to their child and immediately informs them of any injury or illness that requires care other than first aid

c. The assurance that the injury report shall be maintained in the child's file

d. The maintenance of a central log or file of all injuries which occur during program hours and the policy for periodically monitoring the safety record of the program to identify problem areas

e. The maintenance of daily attendance records which indicate each child's attendance, arrival and departure times to be available to program staff at all times

The following sections apply only when services are being provided in a lead site (as defined under Community Based Program Policies of these standards).

The program has a procedure for the care of mildly ill children at the site. The plan shall include, but not be limited to, meeting individual needs for food, drink, rest, play materials, comfort and appropriate indoor activity.

(1) The program shall provide a quiet area for mildly ill children.

(2) Where mildly ill children are cared for in a separate space or room, the program is permitted to care for mixed age groups of children, provided that the staff ratio for the youngest child in the group is met at all times.

(3) Staff who are assigned to care for mildly ill children in a separate space or room are trained in the following areas:
(a) General practices and procedures for the care and comforting of the mildly ill children
(b) Recognition and documentation of symptoms of illness
(c) Taking children's temperature

f. The program does not permit smoking in the EI site.

g. The program does not permit hot liquids in the presence of children.

h. The program has developed procedures for injury prevention and management of medical emergencies during field trips. The program ensures that a first aid kit and the list of emergency numbers for the children are available on any field trip.

7. The program has a plan for administration of medication. The program may accept written parental authorization for specific non-prescription topical medications to be administered.

a. Topical medications such as petroleum jelly, diaper rash ointments, and anti-bacterial ointments which are applied to wounds, rashes, or broken skin must be stored in the original container, labeled with the child's name, and used only for that individual child.

b. Topical medications such as sunscreen, bug spray, and other ointments which are not applied to open wounds, rashes, or broken skin may be generally administered to children with written parental authorization.

8. The program develops with the family a written medical care plan for meeting individual children's specific health care needs, including the procedure for identifying children with allergies and protecting children from exposure to foods, chemicals, or other materials to which they are allergic. (See sample DPH Individualized Health Care Plan [IHCP] in Appendix C of these standards.)

9. The program has written Preventive Health Care Procedures.

a. The program does not admit a child or staff member who has a diagnosed communicable disease (which cannot be contained by Universal Precautions) during the time when it is communicable. The program notifies all parents and participants when any communicable disease, such as measles, mumps and chicken pox has been introduced to the group.

b. The program monitors the environment daily to immediately remove or repair any hazard that may cause injury.

c. The program keeps all toxic substances, poisonous plants, medications, sharp objects, matches, and other hazardous objects in a secured place out of reach of children.

d. Program health records include each child's annual physical and immunization records. (See DPH sample form in Appendix C of these standards.)

All children enrolled in EI are up to date on immunizations according to the recommendation of the Massachusetts Department of Public Health, unless the child's parent has stated in writing that vaccination or immunization conflicts with his/her sincere religious beliefs or if the child's physician has stated in writing that the vaccination or immunization is medically contraindicated.

(1) The program enrolls a child in Early Intervention only if provided with a written statement from a physician which indicates that the child has had a complete physical examination (which includes screening for lead poisoning) within one year prior to admission, or obtains one within one month of admission or obtains written verification from the child's parent(s) that they object to such an examination on the ground that it conflicts with their sincere religious beliefs.

(2) All children are screened for lead at least once between the ages of nine and twelve months and annually thereafter until the age of thirty-six months. For all children enrolled in Early Intervention prior to nine months of age, a statement signed by a physician that the child has been screened for lead is obtained by the EI program.

10. The program has written procedures for regular toileting and diapering of children and for disposal/cleaning of soiled clothing, diapers and linens. The program maintains at least one toilet and washbasin in one or more well ventilated bathrooms.
    a. When adult toilets and washbasins are used, the program provides non-tippable stairs to permit access by those children who are able to use them.
    b. In addition to toilets, portable "potty chairs" may be used in the bathroom or separate room for children unable to use toilets.
    c. If cloth diapers are used, a flush sink or toilet for rinsing diapers and a hand washing facility is provided convenient to the diaper changing area.
    d. Special handrails or other aids shall be provided if required by special needs children.
    e. The program provides both hot and cold running water in washbasins and for water used by children. There is a temperature control to maintain a hot water temperature at no more than one hundred twenty (120) degrees Fahrenheit.
11. Food provided at the site is nutritionally and developmentally appropriate for children.
    a. The program follows parental or physician's orders in preparation or feeding of special diets to children and follows the directions of the parents in regards to any food allergies of the child or where vitamin supplements are required.

b. The program prepares nutritious and tasteful snacks in a manner that makes them appetizing.

c. The program stores, prepares and serves all food and beverages in a manner that ensures that it is free from spoilage and safe for human consumption. The program provides refrigeration and storage for food at not less than 32°F or more than 45°F for food requiring refrigeration. The program stores all food in clean, covered containers. The program shall dispose of milk, formula or food unfinished by a child.

d. The program provides tables and chairs for use by children while eating which are of a type, size and design appropriate to the ages and needs of the children. When feeding tables or highchairs are used, they are designed to prevent children from falling or slipping. The program washes and disinfects the tables or highchair trays used by the children for eating before and after each meal.

e. The program provides eating and drinking utensils that are appropriate to the age and needs of the children.

(1) Eating and drinking utensils are free from defects, cracks and chips.

(2) Disposable cups and plates may be used, but if plastic silverware is used, it shall be heavy duty and dishwasher safe.

(3) All reusable eating and drinking utensils are thoroughly washed and sanitized before reuse.

f. The program provides a source of sanitary drinking water located in, or are convenient to, rooms occupied by children.

12. Requirements for Pets

The program selects pets for the center that are developmentally appropriate for children. Before children are exposed to any animal, staff shall consider the effect on children's health and safety, with special attention to children with compromised immune systems and other

vulnerabilities. Under no circumstances should children come into contact with reptiles at the EI program. (See Appendix C of these standards for additional information.)

13. Physical Facility:

a. All lead sites must have the following:

(1) A current Building Certificate of Inspection. The Building Certificate of Inspection is signed by the building inspector in conjunction with the local fire inspector, states capacity of children and lists an expiration date. If the program site offers toddler groups (without caregivers present), the Building Certificate of Inspection is specific to those rooms used for services and specifies "Code I-2 Usage" (indicating children under 2.9 years) and "E Usage" (children over 2.9 years) or states "infants and toddlers." The certificate of inspection certifies that the program's site complies with the State Building Code (780 CMR 633.0)

(2) Documentation that the site is lead free.

(a) For a facility built prior to 1978, the program provides evidence of a lead paint inspection from the local board of health, or the Massachusetts Department of Public Health, or a private lead paint inspection service and compliance with 105 CMR 460.000 (Department of Public Health Prevention and Control of Lead Poisoning regulations).

(b) For a facility built after 1978, the program provides documentation of the construction date.

(c) The program removes and covers any chipping, flaking or otherwise loose paint or plaster.

(3) Programs are required to have at least one site that is accessible as defined in the Americans with Disabilities Act (ADA). The site must be accessible in all areas (including bathrooms) to children,

staff and caregivers. If not accessible, an action plan to address the deficiency is filed with the Department of Public Health.

(4) All programs have a policy and procedures for regularly scheduled evacuation drills.

(a) The program holds practice evacuation drills at least every other month, at different times of the group schedule. The program documents the date, time and effectiveness of each drill. The program develops specific procedures to be followed for evacuating children with disabilities, and for infants and toddlers.

(b) Emergency Situations: The program develops specific written contingency plans and procedures to deal with fire, natural disasters, and loss of power, heat, or water.

(5) The program facilities are asbestos safe.

(6) Indoor space meets the following requirements: The program shall have a minimum of 40 square feet of **activity space** per child, exclusive of hallways, lockers, wash and toilet rooms, isolation rooms, kitchens, closets, offices or areas regularly used for other purposes.

(a) Floors of rooms used by children are clean, unslippery, smooth and free from cracks, splinters and sharp or protruding objects and other safety hazards.

(b) Ceilings and walls are maintained in good repair, and are clean and free from sharp or protruding objects and other safety hazards.

(c) All steam and hot water pipes and radiators are protected by permanent screens, guards, insulation or any other suitable device which prevents children from coming in contact with them.

(d) All electrical outlets that are within the reach of children are covered with a safety device when not in use. If the covering is a shock stop, it shall be of adequate size to prevent a choking hazard.

(e) Room temperature in rooms occupied by children are maintained at a draft-free temperature of not less than sixty-five

(65) degrees Fahrenheit at zero degrees temperature outside; and at not more than outside temperature when the outside temperature is above eighty (80) degrees Fahrenheit.

(f) There is designated space, separate from children's play or rest areas, for administrative duties and staff or parent conferences.

(g) There is sufficient space, accessible to children for each child to store clothing and other personal items.

(h) The interior of the building is clean and maintained free from rodents and/or insects. The program employs integrated pest management as necessary, and notifies families in advance of any pest management that is planned.

(i) The program provides suitable guards across the insides of any windows that are accessible to children and present a hazard. The program provides suitable guards across the outside of basement windows abutting outdoor play areas.

(j) Guards are placed at the top and bottom of stairwells opening into areas used by children. Pressure gates may not be used at the top of stairs.

(k) Routine, major housekeeping activities such as vacuuming, washing floors and windows are not be carried on in any room while it is occupied by children.

(l) The program provides a barrier, such as a door or gate, which prevents children's access to the kitchen while unsupervised.

(m) The kitchen is maintained in a sanitary condition and garbage receptacles used in the kitchen are emptied and cleaned daily.

(n) The program maintains eating areas that are sufficiently large to fit tables and seats for children eating in an uncrowded manner, and are clean, well-lit and ventilated.

7. The program maintains, or has access to, an outdoor play area of at least 75 square feet per child using it at any one time, including those with disabilities. The outdoor play area is not a requirement

when children are in attendance at the program site less than 4 hours per day. Outdoor play areas are accessible to young children and to children with disabilities.

(a) The outdoor play area is accessible to both direct sunlight and shade.

(b) The average width of such a play area is not less than eight feet.

(c) The outdoor play area is free from hazards including but not limited to: a busy street, poisonous plants, water hazards, debris, broken glass, and any such hazard is fenced by a sturdy, permanently installed barrier which is at least four feet high or otherwise protected.

(d) If the outdoor play area is located on a roof, it is protected by a non-climbable barrier at least seven feet high.

(e) It is not covered with a dangerously harsh or abrasive material and the ground area under swings, slides climbing equipment, seesaws, etc., is not paved or is covered with mats.

(f) Pea gravel and wood chip nuggets are not used.

(g) The ground area and fall zones under swings, slides, and climbing structures are covered with an adequate depth of an impact absorbing material.

14. Equipment:

a. The program uses only equipment, materials, furnishings, toys and games that are appropriate to the needs and developmental level of the children. They are sound, safely constructed, flame retardant, easily cleaned, and free from lead paint, protruding nails, rust and other hazards that may be dangerous to children.

b. The program keeps all equipment, materials, furnishings, toys and games clean and in safe workable condition. Equipment is sturdy, stable and non-tippable.

c. Some materials and equipment are visible and readily accessible to the children in care and shall be arranged so that children may select, remove and replace the materials either independently or with minimum assistance.

d. The program provides equipment and materials that reflect the racial and ethnic composition of the children enrolled.

XII. Program Administration

A. Early Intervention programs must have a full-time primary program administrator. A primary program administrator may be a Program Director or Program Coordinator and must meet the credentialing requirements for one of the disciplines listed in Section V. of these standards. If the administrative responsibilities are shared within an agency, a written administrative plan is developed, designating specific roles and responsibilities to named individuals. The primary program administrator is required to apply for Early Intervention Program Director Certification within three years of assuming that position.

B. Each Early Intervention program has an organizational plan and written policies addressing processes and procedures that are readily available.

1. A written administrative organizational plan that designates the person/persons responsible for:
    a. Administrative oversight
    b. Program development
    c. Budget development and oversight
    d. Program evaluation
    e. Staff development
    f. Hiring, review and termination of staff
    g. Clinical program supervision
    h. Linkage to vendor agency
    i. Linkage to lead agency
    j. Designation of administrative coverage during hours of operation
    k. Facilitation of family involvement and linkage between staff and parents
    l. Approval and assistance in developing health care policies for the program (either a physician or registered nurse)
    m. Coordination of transportation issues and the processing of transportation forms and reports

2. Policies addressing staff rights and responsibilities including:
    a. Salary
    b. Basis for evaluating performance
    c. Benefits
    d. Scheduled holidays/vacations
    e. Conditions for immediate discharge
    f. Grievance procedure
    g. Resignation procedure
    h. Job responsibilities as per individual program job description or contractual arrangements
    i. Professional development
    j. Program hours of operation
3. Personnel records for each staff member, which includes but are not limited to:
    a. Employee's resume or job application
    b. Documentation that the employee has met the credentialing requirements
    c. Record of reference verification
    d. Documentation of completed CORI evaluation
    e. Health records as required in Section XI, C of these standards
    f. Documentation of training required to meet core competencies
    g. Annual performance evaluations
    h. Documentation of EI certification status
4. The following written procedures are available to any interested party on request:
    a. Referral
    b. Screening
    c. Determination of eligibility (evaluation)
    d. Assessment
    e. IFSP development
    f. Service delivery modes

g. Transition

h. Discharge

i. Maintenance, management and preservation of client records in accordance with the due process procedures found in Appendix D of these standards.

j. Release of record with written parental consent

k. Guidelines for referral to specialty providers and services

5. The record kept on each individual child contains the following:

a. Access sheet for recording those authorized persons who have reviewed a record

b. Signed parental consent forms

c. Documentation of referral

d. Completed DPH EIIS (Early Intervention Information System) Forms – Referral, Evaluation, IFSP, Discharge

e. Intake and background information

f. Medical information

g. Reports from other agencies and professionals, as applicable

h. Results of evaluations and assessments

i. IFSPs

j. Documentation of contacts with child and family including date, service type, duration and content of contact, and the legible signature and discipline of the staff person signing the note

.

C. Program staff members are available by phone during regular business hours. Telephone answering machines or voice mail do not satisfy this requirement.

D. Early Intervention programs are grounded in child development and serve young children and their families within the context of understanding the full spectrum of child development. Therefore the Developmental Specialist serves a critical function within the EI core team. Early Intervention programs must employ at least one Developmental Specialist (a, b or c) [who works at least 30 hours per

week] for the first 75 enrolled children. After the first 75 enrolled children, Developmental Specialist hours may be a combination of part-time staff.

Ratios must comply with the following:

- for 1 – 75 enrolled children, one 30-hour per week Developmental Specialist (a, b or c)
- for 76 – 150 enrolled children, an **additional** 30 hours weekly of Developmental Specialist (a, b or c) time
- for 151 – 225 enrolled children, an **additional** 60 hours weekly of Developmental Specialist (a, b or c) time
- etc.

E. Early Intervention programs are expected to comply with the submission of data requested by the Department of Public Health within the timelines established. Timelines for Early Intervention EIIS Forms:

1. Referral Form – within 10 days of referral
2. Evaluation Form – within 10 days of a completed evaluation
3. IFSP Form – within 10 days of IFSP signature
4. Discharge Form –
    a. Client screened out, client screened in but family declines evaluation, client screened in but program loses contact with family following the screening – Discharge Form – within 10 days of inactive date or date of screening.
    b. Client has received a completed evaluation but family declines services or program loses contact with family – Discharge Form within 10 days of inactive date or date of evaluation.
    c. Client has an IFSP - 10 days after the inactive date or last date of active service. (Eligible children may receive services up to but not on their third birthday).

Please note – a transition visit (as defined in Section IX, B of these standards) may occur after the submission of the Discharge Form.

F. Each program conducts an annual self-evaluation. Programs encourage families to participate in this self-evaluation that should include areas such as:

1. Feedback on staff performance
2. Evaluation of program services
3. Review of IFSP process
4. Review of transition procedures
5. Approaches to family participation
6. Review of health and safety procedures
7. Review of interagency agreements and service contracts

G. Each program develops a written procedure for the internal resolution of complaints. Any family with a complaint must be informed again (as they were at intake, see Section VI.C.3) of procedural safeguards and family rights. Families must also be informed of their option to speak to Department of Public Health personnel and/or file a formal written complaint. At the time of the family's complaint, a copy of the Family Rights and Early Intervention Services brochure is given to the family. Due process procedures for families enrolled in Early Intervention are outlined in Appendix D of these standards

H. 1. Department of Public Health policies call for the collection of an Annual Cost Participation Fee. The fee is required for all children with a signed IFSP whose family annual income is equal to or greater than 200% of the published Federal Poverty Income Guidelines (FPIG). Families whose income is 200% - 400% pay an annual fee of $25 ($20 for the 2nd child with a maximum contribution per family of $45) while a family whose income is greater than 400% pays an annual fee of $50 ($50 for the second child for a maximum contribution per family of $100). This fee is applicable to all services with the exception of those services that are exempt from charge per IDEA Secs. 303.520 and 303.521.

2. The services to be rendered and the corresponding costs for such services are referenced in the Department of Public Health Early Intervention Billing Instructions and payable according to the rate structure defined by the Massachusetts Division of Health Care Finance and Policy (formerly known as the Massachusetts Rate Setting Commission.) Services, as appropriate, may be billed to the Department of Public Health, the Division of Medical Assistance, and other third party payers.

3. Each program must assure that no fees are charged for the services that a child is otherwise entitled to receive at no cost to parents. Programs must also assure that the inability of parents of an eligible child to pay for services will not result in the denial of services to the child or the child's family.

4. Each program must assure that services will not be delayed or denied to any child because of disputes between agencies regarding financial or other responsibilities.

2. Fees

The Department of Public Health hereby assures that the following services will be carried out at public expense and for which there will be no fees charged to parents:

a. Implementing the child find requirements in Sec. 303.321.
b. Evaluation and assessment, as included in Sec. 303.322, and including the functions related to evaluation and assessment in Sec. 303.12.
c. Service coordination, as included in Secs. 303.22 and 303.344(g).
d. Administrative and coordinating activities related to:

- The development, review, and evaluation of IFSPs in Secs. 303.340 through 303.346; and

Implementation of the procedural safeguards in subpart E of this part and the other components of the statewide system of early intervention services in subparts D and F of this part.

XIII. Request for Waiver

A. Request for waiver from these standards may be made by submitting a written request to Early Intervention Services, Massachusetts Department of Public Health. (See sample Waiver Request Form in the *Massachusetts Early Intervention Services Policy Book*.)

B. The Massachusetts Department of Public Health retains authority to allow or deny the request.

MASSACHUSETS DEPARTMENT OF PUBLIC HEALTH
EARLY INTERVENTION
ELIGIBILITY CRITERIA DEFINITIONS

CHILD CHARACTERISTICS

NOTE – Factors 1 – 4 apply only to children under 18 months chronological age. Birth or medical records are available to substantiate factors 1 – 4.

1. **Birth weight** – A child meets this risk criterion if the birth weight is less than 1200 grams (2 pounds 10 ½ ounces).

2. **Gestational Age** – A child meets this risk criterion if the gestational age of the child is less than 32 weeks.

   NOTE: Developmental evaluation for eligibility will be based on chronological age, not on adjusted age.

3. **NICU Admission –** This risk criterion applies to a child with a stay in the Neonatal Intensive Care Unit of more than 5 days.

4. **Apgar –** A child meets this risk criterion if the child's Apgar score was **less** than 5 at 5 minutes.

5. **Total Hospital Stay –**
   A child meets this risk criterion if the total number of days as an inpatient in a hospital or extended care facility exceeds 25 days in a 6-month period.

   NOTE: This does not apply to the birth admission of a premature child. Subsequent admissions to a hospital or the transfer hospital stay after NICU admission will apply toward this total.

6. **Intrauterine Growth Retardation/Small for Gestational Age –** A child meets this risk criterion if diagnosed at birth with Intrauterine Growth Retardation (IUGR) or Small for Gestational Age (SGA).

7. **Weight for Age and Weight for Height –**
   a. A child meets this risk criterion when **weight for age** or **weight for height** is less than the 5^{th} percentile or greater than the 95^{th} percentile.
   b. A child meets this risk criterion if the **weight for age** has **dropped** 2 or more major centiles in 3 months if child is under 12 months of age or has dropped 2 or more major centiles in six months if 12 to 36 months of age. A major centile is defined as the major percentiles (5, 10, 25, 50, 75, 90, 95) on the Physical Growth Chart adopted by the National Center for Health Statistics.

c. The above two measurements should be based on the appropriate growth chart approved by the National Center for Health Statistics.

NOTE: If a child has been diagnosed as failure-to-thrive, the child is eligible under established risk.

8. Chronic Feeding Difficulties –

A child meets this risk criterion if any of the following conditions exist over an extended period of time:

- Severe colic
- Stressful or extremely conflicted feedings
- Refusal or inability to eat
- Failure to progress in feeding skills

NOTE: Evidence of this criterion should be documented in the child's record and appropriate outcomes and treatment strategies addressed as determined by the family.

9. Insecure Attachment/Interactional Difficulties -

a. A child meets this risk criterion if the child appears to have **inadequate or disturbed social relationships, depression, or indiscriminate aggressive behavior and the family perceives this as an issue.**

b. In most cases, insecure attachment in infants and toddlers is evidenced by behavior such as persistent failure to initiate or respond to social interactions, fearfulness that does not respond to comforting by caregivers, and indiscriminate sociability. The child's family must perceive this as an issue for it to be included as a risk criterion.

10. Blood Lead Levels –

A child meets this risk criterion with a **venous** (not finger stick) blood lead level of 15 µg/dl (micrograms per deciliter) or more.

11. Suspected Central Nervous System Abnormality –

a. Suspected CNS Abnormalities may include, but are not limited to, the following:
   - Infection: meningitis, encephalitis, maternal infection during pregnancy (TORCH infections – Toxoplasmosis, other (syphilis and HIV), Rubella, CMV, Herpes).
   - Trauma: intracranial hemorrhage, subdural hematoma, epidural hematoma.
   - Metabolic: Profound and persistent hypoglycemia, seizures associated with electrolyte imbalance, profound and persistent neonatal hyperbilirubinemia (greater than 20 mg/dl [milligrams per deciliter]), acidosis
   - Asphyxia: prolonged or recurring apnea, ALTE [apparent life threatening event], suffocation, hypoxia, meconium aspiration, near-drowning
   - In utero drug exposure – nicotine, ethenol, THC, cocaine, amphetamine, phenytoin, barbituates and other.

b. This category may also include the following clinical findings:
   - Abnormal muscle tone

- Persistence of multiple signs of less than optimal sensory and motor patterns, including under-reaction or over-reaction to auditory, visual, or tactile input.

12. Multiple Trauma/Losses –

a. A child meets this risk criterion if he/she has experienced a series of traumas or extreme losses that may impact on the care and/or development of the child. For example, multiple hospitalizations or multiple placements outside the home.
b. This risk factor should be documented in the child's record and appropriate outcomes and treatment strategies addressed as determined by the family.

FAMILY CHARACTERISTICS

NOTE #1 – Regarding children in the care of someone other than the child's biological parent: If the DSS (Department of Social Services) goal is for the reunification of the parent and child, the following risk factors apply based on the biological parent. The EI program should work closely with both the biological and foster families of the child, whenever possible. If there is no goal for reunification with the child's biological parents, the family risk factors are to be based on the family characteristics of the primary caregivers.

NOTE #2 – Determination of risk factors under family characteristics should be determined by family perception.

NOTE #3 – Maternal characteristics apply as risk factors to fathers if the father is the primary caregiver.

1. Maternal Age/Parity –

a. A mother meets this risk criterion if her age at the time of the child's birth was less than 17 years.
b. A mother meets this risk criterion if she has given birth to 3 or more children before the age of 20.

2. **Maternal Education –** A mother meets this risk criterion if she has completed 10 years or less of formal education at the time of the eligibility evaluation.

3. Parental Chronic Illness or Disability –

a. A family meets this risk criterion if one parent has a diagnosed chronic illness or a sensory, mental, or developmental disability which is likely to interfere with or adversely affect the child's development or have an impact on care-giving abilities.
b. Examples of this risk factor may be affective disorders, schizophrenia, sensory limitations, including visual or hearing limitations, and cognitive limitations.

4. Family lacking social supports –

A family meets this risk criterion if the family is geographically or socially isolated and in need of emotional support and services.

NOTE: This risk factor should be documented in the child's record and appropriate outcomes and strategies addressed as determined by the family.

5. Family lacking adequate food, clothing, or shelter –

A family meets this risk criterion if the lack of food, clothing, or a stable housing arrangement cause life stress for the family.

NOTE: This risk factor should be documented in the child's record and appropriate outcomes and strategies addressed as determined by the family.

6. Open or confirmed protective service investigation –

A family meets this risk criterion if the family:

- has an open protective service file with the Department of Social Services, or
- is in the period of investigation for child abuse or neglect, or
- has had its file closed by DSS in the last 3 months

A family who is receiving voluntary services from the Department of Social Services may also meet this criterion.

NOTE: This risk factor should be documented in the child's record and appropriate outcomes and strategies addressed as determined by the family.

7. Substance Abuse –

A family meets this risk criterion if substance abuse is having or may have an adverse affect on the child's development.

NOTE: This risk factor should be documented in the child's record and appropriate outcomes and strategies addressed as determined by the family.

8. Domestic Violence –

a. A family meets this risk criterion if domestic violence is having or may have an adverse affect on the child's emotional development.
b. This category may include physical, sexual, or emotional abuse.

NOTE: This risk factor should be documented in the child's record and appropriate outcomes and strategies addressed as determined by the family.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
EARLY INTERVENTION OPERATIONAL STANDARDS

Appendix B

Interagency Agreements

The Commonwealth of Massachusetts • *Department of Education*
• Executive Office of Health and Human Services • Department of Public Health

U. S. Department of Health & Human Services
Administration for Children and Families • Region 1

TO: Superintendents of Schools
Special Education Directors
Early Intervention Program Directors
Head Start Directors
Child Care Directors
Child Care Resource & Referral Agencies
Advocacy Organizations
Parent Advisory Councils

FROM: Robert V. Antonucci, Commissioner, Department of Education
David H. Mulligan, Commissioner, Department of Public Health
Susan L. Costello, Interim Secretary, Executive Office of Health & Human Services
Hugh Galligan, Administrator, Region 1 Office of the Administration for Children and Families

DATE: November 30, 1994

RE: Interagency Policy on Early Childhood Transitions

Over the course of the last year representatives from the Department of Education, the Department of Public Health, Head Start and Child Care worked together to revise the *Policy on Early Childhood Transitions,* which has been in effect since 1990. The policy was revised after eliciting input from the public through regional forums and written comment on the proposed draft Amendment to the policy. Implementation of the enclosed *Policy of Early Childhood Transitions* will take effect immediately.

The most significant change to the 1990 policy is related to the transition of children who turn three in the late spring and summer. The policy now requires that a child in an Early Intervention program who is eligible for special education services has an Individualized Education Plan (IEP) developed by the child's school district in place, with special education services provided by the school district in accordance with the IEP, commencing on the child's third birthday.

The goal of the policy continues to be the provision of a smooth transition for young children moving from state sponsored Early Intervention programs to community early childhood programs.

We support the premise the policy is based on: that local serve providers, who know the children, their families and the services available, are most effective in developing specific procedures and activities to assure a smooth transition for the child and the family.

The purpose of the policy is to provide a framework for collaboration and for joint planning for the transition of young children, with or at risk of special needs, among local agencies that provide services to young children and their families. We support the concept of collaboration and stress the need for ongoing communication and the use of local interagency councils to carry out the transition process.

Because we believe that all agencies concerned with young children should assume joint responsibility for the methods and means of implementing this policy at both the local and state level, a lead agency is not specified. Effective implementation of the policy is an important step towards developing a seamless system of services for young children.

If you have any questions regarding the policy or need assistance in implementing the policy please contact Ron Behanm, Director of Early Intervention Services, Department of Public Health at (617) 624-5969 or Elisabeth Schaefer, Administrator of Early Learning services, Department of Education at (781) 388-3300, Ext. 341.

ADDENDUM TO AGREEMENT
BETWEEN THE MASSACHUSETTS DEPARTMENT OF EDUCATION,
REGION 1 OFFICE OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES,
THE MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES,
AND THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

CONCERNING INTERAGENCY DISPUTE RESOLUTION
RELATING TO EARLY CHILDHOOD TRANSITIONS

The Department of Education, the Region 1 Office of the Administration for Children and Families, the Executive Office of Health and Human Services and the Department of Public Health are committed to facilitating smooth transitions for young children with or at risk of having special needs and their families.

The purpose of this memorandum of agreement is to outline procedures to be followed by the signatory parties to the Policy on Early Childhood Transitions should disputes arise.

1. The Department of Public Health assures that in the event of a dispute among public agencies regarding responsibility for payment for early intervention services, the Department of Public Health shall assume responsibility for such payment consistent with M.G.L. 111G;

2. The Department of Education (DOE), the Region 1 Office of Administration for Child and Families (ACF), and the Department of Public Health (DPH) shall be responsible for resolving their own internal disputes in a timely manner. Internal agency disputes which are not resolved in a timely manner and intra-agency disputes shall be referred to a committee consisting of the Chairpersons of the Interagency Coordinating Council, the Early Childhood Advisory Council, the Regional Head Start Program Manager, the Director of Early Learning Services at the Department of Education and the Director of Early Intervention Services at the Department of Public Health. Decisions made by this committee shall be final and shall be binding upon DOE, ACF and DPH. The procedures to be utilized by this body are as follows:

a. The DPH shall convene this committee for the purpose of dispute resolution within 10 days of identification of the disputed action.

b. Participating parties shall resolve disputes by consensus. If consensus is not rendered by stated parties within a one month time frame, a simple majority vote shall be taken.

This agreement shall be effective upon the Commonwealth of Massachusetts' participation in the ninth and succeeding years of participation under P.L. 102-119, Part H.

This agreement may be amended through negotiations between the signing parties.

Robert V. Antonucci 7/26/95
Robert V. Antonucci Date
Commissioner
Department of Education

David H. Mulligan 7/24/95
David H. Mulligan Date
Commissioner
Department of Public Health

Hugh H. Galligan 7/24/95
Hugh Galligan Date
Administrator
Region 1 Office of the
Administration for Children and
Families

Gerald Whitburn 7-27-95
Gerald Whitburn Date
Secretary
Executive Office of Health
and Human Services

In acknowledgement of the importance of establishing comprehensive, well-defined procedures for coordinating the transitions of young children and their families as they move from one service agency to another, I endorse this policy and the concept of interagency collaboration.

Robert V. Antonucci 11/28/94
Robert V. Antonucci Date
Commissioner
Massachusetts Department of Education

David H. Mulligan Date
Commissioner
Massachusetts Department of Public Health

Hugh Galligan 11/8/94
Hugh Galligan Date
Administrator
Region 1 Office of the Administration for Children and Families

Susan L. Costello 11/30/94
Susan L. Costello Date
Interim Secretary
Massachusetts Executive Office of Health & Human Services

POLICY ON EARLY CHILDHOOD TRANSITIONS

Massachusetts Department of Public Health
Massachusetts Department of Education
Region 1 Office of the Administration for Children & Families
Massachusetts Executive Office of Health and Human Services

1994

FOREWORD

The Department of Education, the Department of Public Health, the Executive Office of Health and Human Services and the Region 1 Office of the Administration for Children and Families are committed to facilitating smooth transitions for young children with or at risk of having special needs and their families.

This policy has been written by the Massachusetts Department of Education and the Department of Public Health, and is supported by the Executive Office of Health and Human Services, and Head Start (Region 1 Office of the Administration for Children and Families). This policy is based on the idea that local service providers, who know the children, their families, and the services available, are most effective in developing procedures and activities to support the child and the family during transitions. The purpose of this policy is to provide a framework for increased collaboration and joint planning for transitions among agencies serving young children.

TRANSITION POLICY

Comprehensive, well-defined procedures for coordinating the uninterrupted transition from an infant-toddler program to a preschool age program, and then to a kindergarten program, are essential to the educational adjustment and development of a young child with special needs and the well-being of the child's family.

Building upon what has been learned through various initiatives across the state, this policy has been developed to address transitions during the early childhood period. It is designed to have a positive impact on planning, delivery and evaluation of transition practices and to increase the comprehensiveness and usefulness of transition procedures. The intent of this information is not to mandate any one set of transition procedures but to provide guidelines in three targeted areas for local level decision-makers to address as they develop transition plans. These areas of focus include the CHILD, the FAMILY and the AGENCIES.

We support the concept of collaboration as well as the use of existing interagency councils in carrying out the transition process. Because we believe early childhood agencies should assume joint responsibility for the methods and means of implementing this policy at both the local and state levels, a lead agency has not been specified in this document.

FOCUSING ON THE CHILD

For the child, a collaboratively developed transition plan should decrease disruption and gaps in services and enhance the child's adjustment to new settings. Identification of adaptive equipment needs and classroom modifications, opportunities to visit new programs prior to entry, as well as joint assessments and observations, will facilitate the child's ability to participate in the new setting.

Guidelines to enhance a child's transition to the new setting(s) include the following:

- Establish a process which involves parents (*) as well as staff from both the sending and receiving agencies in identifying what is known about the child, what needs to be known, and procedures for gathering further information to avoid duplication of assessments, evaluations, and resources.

- Identify and plan for all adaptive equipment and transportation needs in the receiving program(s).

- When possible and appropriate, arrange for teachers or other appropriate staff persons from the receiving program(s) to observe the child in the sending program's setting and encourage sharing of information about a child's strengths and needs, as well as effective teaching and adaptive strategies by parents and teachers.

- Devise activities to assist the child in adjusting to the new settings, such as arranging pre-placement visits for the child, and arranging for parents, therapists or other appropriate staff persons to observe and/or visit.

(*)Where the word "parent" appears, it should be considered to apply equally to the legal guardian.

FOCUSING ON THE FAMILY

For the family, a collaboratively developed transition plan will provide ongoing opportunities for parent involvement. A plan that accommodates the needs and preferences of parents, and defines the process for meeting the needs of their child during the transition to new programs, will alleviate the anxiety and stress that frequently accompany change.

Recognizing that parents are the most effective advocates for their children, both sending and receiving agencies should include the following components in involving families:

- Involve parents in jointly designing and providing parent training. Training activities need to address the following issues:
  - Referral information and eligibility requirements for community early childhood programs
  - The federal Individuals with Disabilities Education Act
  - The Massachusetts Special Education Law
  - Rights and responsibilities of parents under state and federal special education laws
  - Community resources for advocacy and support
  - Other subjects identified by parents
- Training should be offered as needed, and may include representatives from parent training and advocacy groups, parents who have been through similar transitions with their children, and representatives from the range of local agencies that provide services to young children.
- Offer an opportunity for parents to visit preschool settings which are possible options for the child's future placement.
- Offer an opportunity for parents to meet with both the sending and receiving program staff to share information, answer questions and discuss what and when specific events will occur in the transition process.
- Once placement in the receiving program has been established, a plan should be developed for ongoing family involvement which is culturally sensitive to and consistent with each family's needs and preferences.

FOCUSING ON AGENCIES

For agencies, a collaboratively developed transition plan helps to promote positive, cooperative interactions. Such a plan will facilitate a smooth transition process, with local agencies sharing the responsibilities involved, thus minimizing the burden of the process on any single agency. As agencies begin to collaborate, problems may arise; however, ongoing communication and formal planning among agencies serving young children will increase both knowledge and appreciation for each other's services as well as diminish duplication of effort.

A transition process reflecting the principles in this document should be developed to provide a framework for all sending and receiving agencies (*) serving children having or at risk of having special needs from birth to five, and include the following:

- Plan regular joint meetings (quarterly, semi-annually, etc.) to review up-to-date information on the Comprehensive Special Education Law (Chapter 766), the Act Relative to Early Childhood Intervention Services (Chapter 111G), and other relevant legislation and developments, such as the Early Intervention Operational Standards (DPH). Joint meetings should also identify and address any existing gaps in services.

- Whenever possible, agencies are encouraged to invite staff from other agencies to participate in training.

- Plan for the sharing of responsibilities and resources among sending and receiving agencies and parents on an ongoing basis. Develop and implement a collaborative transition plan which addresses the concerns of children and families.

- Sending programs will provide information annually about children who may need Chapter 766 services to school districts in a way which will ensure the confidentiality of information about families. Early Intervention programs are responsible for making referrals of specific children at least 6 months prior to the child's third birthday.

- A child in an Early Intervention program who is eligible for special education services must have an Individualized Education Plan (IEP) developed by the school district in place, with special education services provided by the school district in accordance with the IEP, commencing on the child's third birthday.

- The Department of Education supports the initiation of the process of transition at two years, six months. To eliminate possible breaks in services for a child transitioning from an Early Intervention program, direct services must begin in accordance with the signed individualized education plan (IEP) no later than a child's third birthday. For planning purposes, sending agencies should contact special education directors to plan the use of community placements well before these programs have reached capacity.

(*) Sending and receiving agencies may include, but are not limited to child care, Early Intervention, Head Start, public/private preschool and kindergarten programs.

Please see:

Appendix A for guidelines to assist agencies in implementing the policy.
Appendix B for steps to follow in interagency planning.

CONCLUSION

As change can be stressful for everyone involved, transition activities should be sensitive to problems that families and children face. They should also facilitate children's ability to participate in new settings, and encourage interagency planning.

The intensified efforts to identify and serve children who have special needs or who are at risk of having special needs mandated under the Individuals with Disabilities Education Act, has generated the need for substantial growth in programs serving young children birth through five. Agencies serving young children will need to expand to accommodate this growth in population. Now, more than ever, the Department of Education, Department of Public Health, Head Start, child care and other agencies need to work together to plan and provide effective services to young children and their families. A carefully planned transition process should benefit children with special needs, their families and agencies, and facilitate the education of children in the least restrictive environment.

Rejection of an IEP:

- School districts are encouraged to conduct the TEAM evaluation for each child referred by an Early Intervention program as soon as possible after the child turns two years and six months old. The parties then have ample time to plan a smooth transition for the child from one program to another, and to resolve any dispute over the IEP before the child turns three.

- The child's parents may reject the IEP proposed by the TEAM or a finding that the child is not in need of special education, and may request mediation or a hearing before the Bureau of Special Education Appeals. While the mediation or hearing process is pending, a child who has turned three and has been found to need special education shall be placed in an appropriate interim program as determined by agreement between the school district and the parents. The school district is responsible for the cost of the child's interim education program. If the school district and the parents do not agree on an interim placement or on whether the child needs special education, either party may request a hearing before the Bureau of Special Education Appeals, which has authority to select an interim placement for the child.

- Nothing precludes the parties or the Bureau of Special Education Appeals from determining that it is appropriate for the child to continue receiving services provided by the Early Intervention program as an interim placement while the dispute over the IEP is being resolved. The school district, not the Department of Public Health, is responsible for the cost of Early Intervention provided to any child over three who is eligible for special education services.

Services provided by a school district for children turning three by December 1:

- Since federal and state regulations require that services to young children with special needs begin on the child's third birthday, school districts are *encouraged* to enroll children turning three by December 1 in early childhood programs at the opening of school in September to minimize disruptions for children, families and staff during the transition process. If a school district has developed an IEP that indicates placement in one of their existing preschool programs for a child turning three years old in the fall, it might be less disruptive for the teacher, child and family to have the child begin the program with her/his classmates when school opens. When making decisions about children starting school before they turn three years old it is important to consider the individual needs and circumstances related to the child and family.

Use of diagnostic evaluation, (Chapter 766 Regulations, paragraph 502.9):

- Diagnostic Evaluation (502.9) may be used for an extended evaluation period when the school district's Evaluation TEAM members believe that the evaluation information is inconclusive and they are unable to develop objectives for the child's IEP. Since young children's development can vary, and diagnostic instruments used for assessing young children can be inadequate and often reveal inconclusive information, it would be appropriate to use a diagnostic evaluation concurrently while completing further assessments. When using a Diagnostic Plan, the evaluation TEAM should follow the procedures described in Chapter 766 Regulations, paragraph (502.9), and specify the questions they are attempting to answer.

- When transitioning young children with special needs from one program to another, a Diagnostic Evaluation (502.9) should be used only when the TEAM determines that there is a need for more information (diagnostic/observational purposes) and not as a general practice.

Transition of children turning three and time lines to follow:

- The child must have an **IEP implemented on the third birthday regardless of when the referral was received.** Therefore, it is essential that **Early Intervention programs make referrals early** to give school districts ample time to plan and act on the referral received.

- On or about the time of the child's second birthday, the Early Intervention program, with parental consent, shall notify the child's school district of the child's identity and the nature of the program s/he is receiving. At or about the time the child reaches age two years six months, the Early Intervention program, with parental consent, shall refer the child to the school district for evaluation.

- To ensure a smooth and timely transition, it is essential for Early Intervention programs and school districts to begin the referral process early to ensure determination of eligibility for special education services and that the necessary time lines are followed in respect to Chapter 766 Regulations, paragraphs 319 (45 school working days to evaluate the child and develop the IEP) and 325.1 (30 days for the parent to sign the IEP and exercise options).

- The school district's obligations to provide special education to the child begins on the child's third birthday. Therefore if an IEP is completed a few months earlier than a child's third birthday and signed by the parent, the school district *may* begin to provide services immediately, but it is not required to provide services until the day of the child's third birthday.

- If a child turns three during the summer and the evaluation TEAM has recommended extended school year (summer) services in the IEP, the school district must provide them. Otherwise, the services may be initiated at the beginning of the upcoming school year.

APPENDIX B

STEPS TO FOLLOW IN INTERAGENCY PLANNING

Transition planning, which includes both a child's family and sending and receiving agency staff, will:

- Identify tasks necessary to implement transition of the child, agree on who will perform them, and establish time lines.

- Establish procedures and time lines for formal referral of the child to the local school system for initiation of Chapter 766 process.

- Plan for transfer of records and any additional assessments, avoiding unnecessary or duplicative evaluations.

- Agree on pre-placement activities that facilitate direct contact between the child, the parent and the receiving teacher, and that support parents in planning for adjustment to the new setting.

- Pre-placement activities should include:
  - parent visits to possible program options
  - information sharing between teachers in sending and receiving agencies
  - arrangement for parent training (planned jointly by involved agencies)
  - consultations between sending teacher/case manager and family and receiving teacher

- Plan for follow-up activities. Evaluations of the process should be planned and carried out between the family and the agencies involved.

<u>Implementation of the Transition Process</u>
Activities formulated in the planning process [e.g., formal information-sharing meetings(s); formal referral to the local school system; scheduled pre-placement activities, and follow-up] will be initiated and carried out through the collaborative and cooperative efforts of the families and agencies involved.

INTERAGENCY AGREEMENT BETWEEN THE OFFICE OF CHILD CARE SERVICES AND THE DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF PURPOSE

The Office of Child Care Services (OCCS) is mandated to license and regulate child care programs throughout the Commonwealth and to promote the development of programs and services to all children emphasizing programs for children with special needs. G.L. c. 28A, § 4.

The Massachusetts Department of Public Health (DPH) has statutory responsibility for the establishment of a statewide Early Intervention (EI) system and the responsibility for monitoring the effectiveness of this system.

Because OCCS and DPH are mandated to ensure that the children of the Commonwealth have access to services that support the needs of all children, including those with disabilities, OCCS and DPH undertake the following mutual commitment toward maximizing the availability of early intervention services and developmentally sound child care in OCCS licensed facilities.

1. DPH agrees that center-based child group component of EI programs are subject to OCCS licensure and regulations. DPH further agrees that OCCS regulations shall govern the supervision of the center-based child group component; the health and safety standards for the facility, furnishings and equipment; policies addressing the care of children; and the implementation of the early childhood education curriculum.

OCCS agrees to develop licensing guidelines that support DPH contract and operational standards for the effective delivery of early intervention services. OCCS further agrees that DPH contract and operational standards shall govern the administration and delivery of all EI services; development of Individualized Family Service Plans; and Recordkeeping functions.

OCCS and DPH agree, as appropriate, to use variances and waivers as alternative methods of achieving program compliance.

2. OCCS and DPH agree that the administration of the center-based component of all OCCS licensed EI programs shall include a person who is qualified as both a "Lead Teacher" under 102 CMR 7.21(c)(2) and as an "Educator" under Section V of the EI Standards. An administrator who is Director I or Director II qualified under 102 CMR 7.21 may be required as determined by the component's licensed capacity.

3. OCCS and DPH agree, to the extent permitted by law; to share projected visit schedules; conduct joint visits for the purpose of licensing studies and contract monitoring; exchange visit reports, investigation reports, other complaint or investigation materials or other information and make trainings available to agency staff.

4. DPH agrees to provide OCCS with a list of the locations of all contracted EI programs, including satellite sites.

OCCS agrees to provide DPH with a list of all licensed EI facilities.

5. DPH agrees to verify with OCCS that a program has been either licensed or exempted before initiating a contract for a new EI program.

6. OCCS agrees to notify DPH of any corrective or legal action taken against an EI program and its resolution. OCCS further agrees to provide a copy of the legal document(s) to DPH.

DPH agrees to notify OCCS of any comparable action taken against a licensed EI program for failure to comply with its operational standards. DPH further agrees to provide OCCS with documentation relating to the action.

This Agreement may be amended or terminated, with or without cause, by thirty (30) days' written notice by either party.

DEPARTMENT OF PUBLIC HEALTH

Howard K. Koh MD MPH
By: Howard Koh
Commissioner 11/22/99

OFFICE OF CHILD CARE SERVICES

Ardith Wieworka 10/19/99
By: Ardith Wieworka
Commissioner

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
EARLY INTERVENTION OPERATIONAL STANDARDS

Appendix C

Health and Safety Resources

Health and Safety Tips

Latex Allergies

Latex Reaction in Child Care

Child care food and health care workers daily use rubber gloves or other products made with latex. Latex (the sap from the Hevea brasiliensis tree) is used to make “rubber” gloves. Some people react to latex products. The reaction may be mild or severe. Some people may have watery eyes or skin irritation on the hands. Others may have severe allergy like breathing difficulty or collapse.

How do you know if you will react or if the children in your care will react to latex?

Workers may not know they will have a reaction to latex until they are exposed and have symptoms. The reaction may be mistaken for a skin reaction from frequent handwashing or a mild “cold” (watery eyes, runny nose, sneeze or cough). Parents of infants or other young children may not know their child will react to latex. When a latex reaction is suspected the person needs a medical evaluation. Employers should urge workers to seek medical evaluation and to receive medical guidance about work task. When children are suspected of having a latex reaction, child care providers should work with parents to secure medical evaluation and guidance for the child care setting.

What does a medical evaluation for latex reaction mean?

The health care provider will ask many questions about why a person suspects they have a latex reaction. Questions about the type of reaction, frequency of reaction, and exposure to latex are typical. The health care provider will examine any skin reactions. You may have blood test to determine the level of latex sensitivity. Your health care provider may ask you to see a medical specialist depending on your reaction. Written guidelines and information should be given to you to assist you in determining work task to limit or prevent exposure to latex.

What should workers with a known latex reaction do?

People with latex reaction should *wear a medical identification bracelet* or other device stating the latex sensitivity. Workers sensitive to latex should obtain guidelines from their health care provider about appropriate products to use when doing child care task. Guidelines for workers should be shared with the child care employer and job task reviewed. Gloves must be made of vinyl or some other substance that does not contain or cross-react with latex should be available at diaper changing areas, first aid kits, emergency supplies, food service, and in play items or spaces. Other common supplies that contain latex, such as rubber bands, should also be removed from the environment.[2] Workers with latex reaction should *read the label* of all products suspected of containing latex. If you have a known or suspected latex reaction do not use latex gloves. The workplace should provide powder-free gloves with reduced protein

content for co-workers. The latex proteins, that cause allergies, attach to the powder used in gloves. This powder can become airborne when the gloves are removed and be inhaled by those with latex allergies. For this reason, non-latex synthetic gloves should be available for every worker's use.

What if a child has a latex reaction?

All child care providers within the facility need to be aware of any child with latex reaction. *Latex products should not be used* for these children. Child care providers should work with parents and follow the child's medical guidelines for using non-latex products. Gloves must be made of vinyl or some other substance that does not contain or cross-react with latex should be available at diaper changing areas, first aid kits, emergency supplies, food service, and in play items or spaces. Other common supplies that contain latex, such as rubber bands, should also be removed from the environment. [2]

Is latex reaction really a serious concern?

The latex reaction usually is seen as skin irritation to the hands or mild symptoms like runny nose and watering eyes. But, for some people the reaction to latex can be life threatening. Workers and older children with latex allergy should wear identification noting the latex sensitivity. It is not practical or safe for young children to wear medical identification—so parents and child care workers must be diligent about notifying all care providers of the child's latex sensitivity.

Where can I learn more about latex sensitivity?

Ask you public library to help you find appropriate information sources. Your health care provider should have written information for patients with latex reactions. The U.S. government has several agencies that oversee latex production and sales.

Resources

Consumer Product Safety Commission, Office of Information and Public Affairs, Washington, D.C., 20207. Telephone voice 800-638-2772, TTY 800-638-8270. Internet: www.cpsc.gov

Food and Drug Administration, HFI-40, Rockville, MD 20857. Telephone 1-888-463-6332. Email: webmail@oc.fda.gov. Internet: www.fda.gov

National Institute of Occupational Safety and Health, Centers for Disease Control and Prevention, Telephone 1-800-356-4674. Email: pubstaft@cdc.gov. Internet: http://www.cdc.gov/niosh/homepage.html.

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[1] Preventing Allergic Reactions to Natural Rubber Latex in the Workplace, National Institute of Occupational Safety and Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Publication No. 97-135, July 1998.

[2] American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care. Caring For Our Children National Health and Safety Performance Standards: Guidelines for Out-Of-Home Child Care Programs Second Edition. 2002. pg. 95.

[3] Latex Allergy, A Prevention Guide, National Institute of Occupational Safety and Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Publication No. 98-113, Feb. 1999.

This document was prepared by the National Resource Center for Health and Safety in Child Care
For any further questions please contact us at 1-800-598-5437 or natl.child.res.ctr@uchsc.edu

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
EARLY INTERVENTION SERVICES

Infectious Disease Control and Sanitation Requirements

I. Infectious Disease

A. The program ensures that staff, volunteers and children wash their hands with liquid soap and running water and dry them using disposable towels at least at the following times:

1. before eating or handling food or food preparation materials
2. after diapering, toilet training, and toileting
3. after coming into contact with bodily fluids and discharges
4. after handling pets or other animals or their equipment
5. before and after administering medication
6. after cleaning.

B. The following specified equipment, items or surfaces are washed with soap and water and disinfectant using the following schedule or more frequently:

After each use:

1. toilet training chairs which have first been emptied into a toilet
2. sinks and faucets used for hand washing after sink is used for rinsing a toilet training chair
3. diapering surfaces
4. toys mouthed by children mops used for cleaning body fluids
5. bibs
6. thermometers.

At least daily:

1. toilets and toilet seats
2. containers, including lids, used to hod soiled diapers
3. sinks and sink faucets
4. drinking fountains
5. water table and water play equipment
6. play tables
7. smooth surfaced non-porous floors
8. mops used for cleaning
9. cloth washcloths and towels

II. Sanitation and Hygiene Procedures for Diapering and Toileting

1. Each child's diaper is changed when wet or soiled.
2. A supply of clean, dry diapers is maintained adequate to meet the needs of children.
3. A disposable covering is used on changing surfaces which is of adequate size to prevent the child from coming in contact with changing surface and changed after each child has been diapered and the diaper is disposed of in a closed container.
4. Running water is adjacent to diapering area for hand washing (adaptations for running water may be acceptable).
5. Each child is washed and dried with individual washing materials during each diaper change. After changing, child's hands are washed with liquid soap and running water; hands are dried with individual or disposable towels.
6. Changing surface is washed and disinfected after each use.
7. Soiled disposable diapers are placed in a closed container that is lined with a leakproof disposable lining. These diapers are removed from the facility daily or more frequently as necessary.
8. Soiled non-disposable diapers and soiled clothing are place in an individual sealed, plastic container labeled with the child's name and returned to child's caregiver at the end of the day.
9. Staff wash their hands with liquid soap and running water and dry hands with individual or disposable towels after changing child's diaper or helping child with toileting.
10. Changing surface is smooth, intact, impervious to water and easily cleaned.
11. Diapering areas and hand washing facilities are separate from areas used for food preparation and food service.
12. A common changing table or diapering surface is not used for any other purpose.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM

ATTENTION:
PROOF OF IMMUNITY FOR CHILD CARE STAFF EFFECTIVE IN 2001

In accordance with OCCS regulations, all child care staff must provide proof of immunity to measles mumps, and rubella. **Effective September 2001, the criteria for adequate proof of immunity** are as follows:

- For all individuals born **in or after 1957**, regardless of country of birth:
  - 2 doses of MMR vaccine (or 2 doses of a measles-containing vaccine and 1 dose each of mumps and rubella vaccines); or
  - Laboratory tests to confirm immunity to measles, mumps and rubella.
- For individuals born **before 1957 in the U.S.**:
  - These individuals are considered immune to measles, mumps, and rubella and do not need any further documentation. However, it is recommended that women who could become pregnant receive 1 dose of MMR vaccine regardless of age.
- For individuals born **before 1957 in countries other than the U.S.**:
  - 1 dose of MMR; or
  - Laboratory tests to confirm immunity to measles, mumps and rubella.

We suggest that your employees have their health care providers complete the enclosed *Certificate of Immunization* to document immunity to measles, mumps, and rubella. Please review the enclosed materials, which describe how to document immunity. If you have any questions, call the Massachusetts Immunization Program at (617) 983-6800.

ADDITIONAL IMMUNIZATION RECOMMENDATIONS FOR STAFF

The Massachusetts Immunization Program also *recommends*:

1) all staff receive a Td booster every 10 years;
2) all staff who do not have a reliable history of chickenpox disease (personal recall, physician diagnosis, or laboratory test) receive varicella vaccine; and
3) pertinent staff (those whose responsibilities may include first aid) be offered hepatitis B vaccine.

Immunizations Required for All Child Care Staff

---- Effective September 2001 ----

	Born in or after 1957, regardless of country of birth	Born before 1957, in the U.S.*	Born before 1957, in countries other than the U.S.
Measles	2 doses	N/A	1 dose
Mumps	1 dose	N/A	1 dose
Rubella	1 dose	N/A	1 dose

* It is recommended that women who could become pregnant receive 1 dose of MMR vaccine, regardless of age.

Bureau of Communicable Disease Control

- HIV/AIDS Surveillance
- Epidemiology & Immunization
- Tuberculosis Prevention & Control
- STD Prevention
- Refugee & Immigrant Health

Related Sites

- Centers for Disease Control

Contact Information

Division of Epidemiology and Immunization
State Laboratory Institute
305 South Street
Jamaica Plain, MA 02130

Robert Goldstein, MPH
Director

Tel. (617) 983-6800
Fax (617) 983-6840

Public Health Fact Sheet - Adult Immunization

Why do adults need to be immunized?
Many infections preventable with vaccines are more dangerous in adults than in children. Many adults think they are too old for immunization, but they are wrong. Adults should ask their doctor or nurse about tetanus-diphtheria vaccine (Td), pneumococcal vaccine, and annual flu shots, especially at visits on or around the 50th and 65th birthdays. Some adults will need other vaccines because of their jobs, travel plans or health problems.

Tetanus and Diphtheria
Tetanus (lockjaw) kills 1 of every 3 people who get it. Germs that make tetanus toxin (poison) cause tetanus after entering the body, usually through a cut or scrape. The cut does not have to show any sign of infection and does not have to be large or deep to lead to tetanus.
Diphtheria is dangerous; 1 of every 10 people who get it dies from it. The signs of diphtheria include fever and sore throat with swelling, causing swallowing problems and suffocation. It is rare in the U.S. because so many people have been vaccinated, but it is still common in other parts of the world.
Tetanus-Diphtheria Vaccine (Td)- Tetanus and diphtheria vaccines are usually given as one shot called Td. Anyone who has never had Td should start with a series of 3 shots. Everyone needs a booster shot every 10 years. A booster may be given sooner if a person gets certain kinds of wounds.

Flu (Influenza)
Flu is a very contagious disease caused by influenza viruses. Signs include sudden high fever, muscle ache, sore throat and cough. Most people who catch it get well within a week, but flu sometimes leads to pneumonia, which can be fatal. People at high risk for pneumonia should get a flu shot every year. They include anyone 50 years old or older, residents of long-term care facilities, people of any age who have chronic medical problems (heart or lung disease, asthma, diabetes, etc.), pregnant women, and people whose immune systems have been weakened (by cancer, AIDS, or other cause). People who work or live with a high-risk person should also get a flu shot so they don't spread the flu. People who just want to avoid the flu can also get the shot. A new flu shot is needed each year. The best time to get it is in the fall, but it's not too late to get it later, even after December. Flu vaccine is made from killed viruses so it cannot give you the flu.

Pneumococcal Disease
Pneumococcal disease is a disease that is caused by bacteria (germs) that can infect the lungs (pneumonia), the blood (bacteremia), and the membrane that covers the brain (meningitis). People 65 years old and older, people of any age with certain medical conditions, and people with weakened immune systems should get pneumococcal vaccine. Most people only need one dose, which can safely be given at the same time as a flu shot or at any other time during the year. Some people may need a booster shot, so ask your doctor or nurse.

Hepatitis B
Hepatitis B is a disease caused by a virus that can damage the liver. Symptoms include flu-like illness, extreme tiredness and jaundice (yellowing of light skin and the whites of the eyes), but often the disease occurs without noticeable symptoms. This virus can cause chronic hepatitis, which can be fatal. Health care workers, people with multiple sex partners, IV drug users, sexual partners and household members of

hepatitis B carriers, and anyone else likely to have contact with infected blood or body fluids should get the vaccine. People who visit countries where hepatitis B is common should also get the vaccine. Three doses are needed to protect against hepatitis B.

Measles, Mumps and Rubella

Measles is caused by a virus and its signs include rash, fever, sore throat, dry cough, and runny nose. Ear infections, pneumonia, swelling of the brain, and death can all result from measles. The risk of death from measles is highest among infants and adults. Many adults born after 1956 never had measles (but may think they did) and never got the vaccine.

Mumps is caused by a virus and its signs include swelling of the salivary (spit) glands. Mumps is more common in children than in adults, but it is more likely to cause serious problems in adults. These problems can include swelling of and damage to the testicles, ovaries, pancreas, thyroid, kidneys, heart, joints, or the thin membrane that covers the brain and spinal cord.

Rubella is caused by a virus and its signs include low fever, joint pain, and rash in some people. Rubella is usually a mild disease in both children and adults, but it can cause severe birth defects or miscarriage if a woman gets rubella while pregnant.

Measles, Mumps and Rubella Vaccine (MMR) - Measles, mumps and rubella vaccines are usually combined in one shot called MMR. People born after 1956 need 2 shots of MMR, especially if they are health care workers, people traveling overseas, college students or persons living in institutional settings, such as group homes. These people are at higher risk of catching and spreading measles. Adults born in the U.S. before 1957 are usually considered immune, but they should get one dose of MMR if they are women who could become pregnant, health care workers, or college students. Women who are already pregnant should not be vaccinated until after the baby is born. One dose of MMR is also recommended for adults born outside of the U.S., regardless of year of birth.

Varicella (Chickenpox)

Chickenpox is caused by a virus. The symptoms include fever, cough, and rash that may become blisters that crust over. Adults, pregnant women, and people with weak immune systems have more severe disease and are at higher risk for complications such as pneumonia and infections of the brain, kidneys and liver. Adults who have not had chicken pox, especially child care and health care workers, and people living with people with weak immune systems, should be vaccinated. People 13 years old or older need 2 doses of varicella vaccine.

Travel Vaccinations

There are a number of vaccines that are not routine for adults, but are recommended for travel to certain areas. These include hepatitis A, typhoid, yellow fever and Japanese encephalitis vaccines. To find out if you need shots for travel, contact a doctor, board of health, or the CDC Travel Information website at http://www.cdc.gov/travel, or call 1-877-394-8747, at least 6 weeks before leaving the country.

Where can you get more information?

- Your doctor, nurse or clinic or your local board of health (listed in the phone book under local government).
- The Massachusetts Department of Public Health Immunization Program (617) 983-6800 or toll-free at

1-888-658-2850, or at a MDPH Regional Office below, or on the MDPH Website at http://www.state.ma.us/dph/.
Northeast Regional Office, Tewksbury (978) 851-7261

Central Regional Office, West Boylston (508) 792-7880

Southeast Regional Office, Lakeville (508) 947-1231
Metro/Boston* Regional Office, Jamaica Plain (617) 983-6860
Western Regional Office, Amherst (413) 545-6600

*Boston providers and residents my also call the Boston Public Health Commission at (617) 534-5611.

CDC National Immunization Information Hotline:

- English: 1-800-232-2522 or Spanish: 1-800-232-0233 (Mon – Fri, 8am – 1pm)
- TTY: 1-800-2437889 (Mon – Fri, 10am – 10pm)

June 2002

PUBLIC HEALTH FACT SHEET

Measles

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is measles?

Measles is a very contagious disease that usually lasts a week or two. Measles looks and feels like a cold at first. A cough, high fever, runny nose, and red, watery eyes are common. A few days later, a red, blotchy rash starts on the face, then spreads to the rest of the body.

Is measles dangerous?

Yes. Measles often causes ear infections and pneumonia. Deafness, blindness, seizure disorders and other brain diseases stemming from measles are less common. Measles can also cause swelling of the brain and death, although this is rare in the U.S. Measles is most dangerous for infants, pregnant women, and people with weakened immune systems.

How is measles spread?

Measles is more contagious than almost any other disease. The virus that causes measles lives in the nose and throat and is sprayed into the air when an infected person sneezes, coughs or talks, and can stay in the air for up to 2 hours. Other people nearby can then inhale the virus. Touching tissues or sharing a cup used by someone who has measles can also spread the virus. People with measles can spread the disease starting 4 days before until 4 days after the rash begins. The first symptoms appear 10–14 days after a person is exposed.

Who gets measles?

- Anyone who never had measles and has never been vaccinated.
- Babies younger than 12 months old, because they are too young to be vaccinated.
- Adults who were vaccinated before 1968, because some early vaccines did not give lasting protection.

How is measles diagnosed?

Because measles can look like other diseases that cause a rash, the only sure test for measles is a blood test.

How can you prevent measles?

- Protect your children by having them vaccinated when they are 12–15 months old, and again when they are about to enter kindergarten. Measles vaccine is usually given in a shot called MMR, which protects against mumps and rubella as well as measles. There are now many fewer cases of these three diseases because children get MMR vaccine.
- State regulations require certain groups to be vaccinated against measles. Kindergarten, 7th grade and college students must have proof of at least two doses of live measles vaccine, or blood test results proving they are immune, before they enroll. Some health care workers, and all children in licensed day care or preschool who are 15 months and older, are required to have one dose of MMR vaccine.
- If you have been exposed to measles, talk to your doctor or nurse right away to see if you need a vaccination. If you get the vaccine less than 3 days (72 hours) after being exposed, it will help protect you against measles. People who cannot be vaccinated can be treated with immune globulin (IG) up to 6 days after exposure. IG may not prevent measles but it does make the disease milder.

- People with measles should be kept away from people who are not immune until they are well again. State regulations require anyone who catches measles to be isolated for 4 days after the rash appears. That means they must be kept away from public places like day care centers, school and work.

Is MMR vaccine safe?

Yes, it is safe for most people. However, a vaccine, like any medicine, is capable of causing problems like fever, mild rash, temporary pain or stiffness in the joints, and allergic reactions. More severe problems are very rare. Getting MMR vaccine is much safer than getting measles, and most people do not have any problems with it.

Who should not get MMR vaccine?

- People who have serious allergies to gelatin, the drug neomycin, or a previous dose of the vaccine.
- Pregnant women should not get MMR vaccine until after they deliver their babies.
- People with cancer, HIV, or other problems that weaken the immune system should check with their doctor or nurse before being vaccinated.
- People who have recently had a transfusion or were given other blood products should check with their doctor or nurse before being vaccinated.
- People with high fevers should not be vaccinated until after the fever and other symptoms are gone.

Should health care workers be extra careful about measles?

Yes. Health care workers who are not immune to measles can pick up the virus and spread it to their patients, who might then become dangerously ill. That is why it is recommended that some health care workers who never had measles and cannot prove that they were vaccinated must stay out of work from the 5th day through the 21st day after being exposed to measles or at least 4 days after the rash appears. Health care workers born in 1957 or later who have direct patient contact should have proof of two doses of measles vaccine, with the first received after their first birthday and both doses received after 1967. Older health care workers should think about having at least one dose of measles vaccine to make sure they are immune.

Where can you get more information?

- **Your doctor, nurse or clinic**
- **Your local board of health** (listed in the phone book under local government)
- **The Massachusetts Department of Public Health** (MDPH) Immunization Program at **(617) 983-6800** or toll-free at **1-888-658-2850** or on the MDPH Website at **http://www.state.ma.us/dph/**, or the regional offices of the MDPH Immunization Program:

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Western Immunization Office, Amherst	(413) 545-6600

*For Boston providers/residents, you may also call the Boston Health Commission at (617) 534-5611.

June 1999

PUBLIC HEALTH FACT SHEET

Mumps

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is mumps?

Mumps is a contagious disease caused by a virus. The most common symptom is swollen and tender salivary glands, usually one or both glands near the ear and the back of the jaw. However, as many as 1 in 3 people with mumps do not have enough swelling to show. Other symptoms include fever, headache, stiff neck and loss of appetite. Although mumps is more common in children than in adults, it is more likely to cause serious problems in adults.

Is mumps dangerous?

Mumps is usually a mild disease, especially in young children. However, it causes swollen testicles in 1 out of 4 men, and swollen ovaries in 1 out of 20 women who get mumps. The swelling can cause sterility, although this is very rare.

Mumps sometimes causes swelling in other organs, including the heart and joints, that can lead to permanent damage. The most serious problems caused by mumps are swelling of the thin membrane that covers the brain and spinal cord (meningitis) and swelling of the brain itself (encephalitis). Both of these problems are dangerous, but both are also very rare.

Mumps infection during the first trimester of pregnancy can increase the risk of miscarriage.

How is mumps spread?

The virus that causes mumps lives in the nose, mouth, and throat, and is sprayed into the air when an infected person sneezes, coughs, or talks. Other people nearby can then inhale the virus. Touching a tissue or sharing a cup used by someone with mumps can also spread the virus. People with mumps are contagious from 2 days before until 9 days after their glands start swelling. Symptoms most often appear 2-3 weeks after a person is exposed.

Who gets mumps?

- Anyone who never had mumps and has never been vaccinated.
- Babies younger than 12 months old, because they are too young to be vaccinated.

How is mumps diagnosed?

Mumps is most often diagnosed by its symptoms, but this is not always reliable. There is also a blood test for the disease.

How can you prevent mumps?

- Protect your children by having them vaccinated when they are 12–15 months old, and again when they are about to enter kindergarten. Mumps vaccine is usually given in a shot called MMR, which protects against measles, mumps and rubella. There are now many fewer cases of these three diseases because children get MMR vaccine.

- State regulations require certain groups to be vaccinated against mumps. Kindergarten, 7th grade and college students to have proof of at least two doses of live mumps vaccine, or blood test results proving they are immune, before they enroll. Some health care workers, and all children in licensed day care or preschool who are 15 months and older, are required to have one dose of MMR vaccine.

Is MMR vaccine safe?

Yes, it is safe for most people. However, a vaccine, like any medicine, is capable of causing problems like fever, mild rash, temporary pain or stiffness in the joints, and allergic reactions. More severe problems are very rare. Getting MMR vaccine is much safer than getting measles, and most people do not have any problems with it.

Who should not get MMR vaccine?

- People who have serious allergies to gelatin, the drug neomycin, or previous dose of the vaccine.
- Pregnant women should not get MMR vaccine until after they deliver their babies.
- People with cancer, HIV, or other problems that weaken the immune system should check with their doctor or nurse before being vaccinated.
- People who have recently had a transfusion or were given other blood products should check with their doctor or nurse before being vaccinated.
- People with high fevers should not be vaccinated until after the fever and other symptoms are gone.

Where can you get more information?

- **Your doctor, nurse or health clinic**
- **Your local board of health** (listed in the phone book under local government)
- **The Massachusetts Department of Public Health** (MDPH) Immunization Program at **(617) 983-6800** or toll-free at **1-888-658-2850** or on the MDPH Website at **http://www.state.ma.us/dph/**, or the regional offices of the MDPH Immunization Program:

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June 1999

PUBLIC HEALTH FACT SHEET

Rubella
(German measles)

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is rubella?

Rubella (also called German measles) is a very contagious disease caused by a virus. The most common symptoms are mild fever, headache, swelling of the lymph glands (often in the back of the neck), and a rash that lasts about three days. About half of all people who get the disease do not get the rash. Some people get swollen and painful joints, but these symptoms don't last long. The disease can also cause swelling of the brain (encephalitis), but this is very rare.It can cause a rash and other symptoms.

Is rubella dangerous?

Yes, it is very dangerous if a woman gets rubella while she is pregnant. Rubella can cause blindness, heart problems, mental retardation or death in babies before they are born. It can also cause miscarriages. Because of this, all women who want to have children should have their blood tested to make sure that they are immune to rubella even if born before 1957.

How is rubella spread?

The virus that causes rubella lives in the nose and throat and is sprayed into the air when an infected person sneezes, coughs or talks. Other people nearby can then inhale the virus. Touching tissues or sharing a cup used by someone with rubella also spreads the virus. People with rubella can spread the disease starting 7 days before until 7 days after the rash starts. The first symptoms appear about 16–18 days after a person is exposed.

Who gets rubella?

- Anyone who has never had rubella and has never been vaccinated.
- Babies younger than 12 months old, because they are too young to be vaccinated.
- Adults who were vaccinated before 1968, because some early vaccines did not give lasting protection.

How is rubella diagnosed?

Because rubella can look like other diseases that cause a rash, the only sure test for rubella is a blood test.

How can you prevent rubella?

- Protect your children by having them vaccinated when they are 12–15 months old. Rubella vaccine is usually given in a shot called MMR, which protects against mumps and measles as well as rubella. There are now many fewer cases of these three diseases because children get MMR vaccine.
- State regulations require certain groups to be vaccinated against measles. Kindergarten, 7th grade and college students to have proof of at least two doses of live measles vaccine, or blood test results proving they are immune, before they enroll. Some health care workers, and all children in licensed day care or preschool who are 15 months and older, are required to have one dose of MMR vaccine.
- Women who plan to have children and who are not immune should get MMR vaccine at least 3 months before getting pregnant.
- If you are not immune to rubella, you should get MMR vaccine. It will not protect you this time, but it will protect you against measles, mumps and rubella in the future.

- People with rubella should be kept away from people who are not immune until they are well again. State regulations require anyone who catches rubella to be isolated for 7 days after the rash appears. That means they must be kept away from public places like day care centers, school and work.

Is MMR vaccine safe?

Yes, it is safe for most people. However, a vaccine, like any medicine, is capable of causing problems like fever, mild rash, temporary pain or stiffness in the joints, and allergic reactions. More severe problems are very rare. Getting MMR vaccine is much safer than getting measles, and most people do not have any problems with it.

Who should not get MMR vaccine?

- People who have serious allergies to gelatin, the drug neomycin, or a previous dose of the vaccine.
- Pregnant women should not get MMR vaccine until after they deliver their babies.
- People with cancer, HIV, or other problems that weaken the immune system should check with their doctor or nurse before being vaccinated.
- People who have recently had a transfusion or were given other blood products should check with their doctor or nurse before being vaccinated.
- People with high fevers should not be vaccinated until after the fever and other symptoms are gone.

Should health care workers be extra careful about rubella?

Yes. Health care workers who are not immune to rubella can pick up the virus and spread it to their co-workers and patients. The results could be tragic if one of them is pregnant and not immune. That is why it is recommended that some health care workers who have no record of rubella vaccination or whose blood tests show that they are not immune must stay out of work from the 7th day through the 21st day after being exposed to the disease. Health care workers should have proof of immunity to rubella, either through vaccination or a blood test.

Where can you get more information?

- **Your doctor, nurse or clinic**
- **Your local board of health** (listed in the phone book under local government)
- **The Massachusetts Department of Public Health** (MDPH) Immunization Program **(617) 983-6800** or toll-free at **1-888-658-2850** or on the MDPH Website at **http://www.state.ma.us/dph/**, or the regional office of the MDPH immunization program:

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June 1999

PUBLIC HEALTH FACT SHEET

Chickenpox
(Varicella)

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is chickenpox?

Chickenpox, also called varicella, is caused by a very contagious virus. People with chickenpox get an itchy rash that looks like tiny blisters. It usually starts on the face, stomach, chest or back, and spreads to other parts of the body. A mild fever, tiredness, and slight body discomfort usually come with the rash. Anyone who hasn't had chickenpox already can get it, but it is most common among children under 15 years old. More than 90% of US adults have already had chickenpox.

Is chickenpox dangerous?

Yes, it can be. Chickenpox can lead to severe skin infection, scars, pneumonia,brain damage and death. About 12,000 people are hospitalized for chickenpox each year in the US, and about 100 people die. Serious complications (such as pneumonia) are rare, but are more common in newborns, pregnant women, people with weak immune systems, and adults in general. A person who has had chickenpox can also get a painful rash called shingles years later.

How is chickenpox spread?

Chickenpox is spread from person to person by coughing, sneezing, or touching the rash. People with chickenpox can spread the disease from 1-2 days before symptoms start until all the lesions are crusted over (usually about 5 days). Symptoms usually appear about 2–3 weeks after exposure to the virus. However, people with weak immune systems are contagious longer, usually as long as new blisters keep appearing. Under state regulations, people with chickenpox must stay out of school and work until all their blisters have dried and crusted.

Who gets chickenpox?

- Anyone who has never had chickenpox and has never been vaccinated.
- Babies younger than 12 months old, because they are too young to be vaccinated.

How can you prevent chickenpox?

- Protect your children by having them vaccinated when they are 12-18 months old, or at any age after that if they have never had chickenpox. It is important to make sure susceptible children get vaccinated before their 13th birthday due to an increased risk of complications after this age.
- Adolescents and adults who are not immune to chickenpox, particularly those who are health care workers or who live with someone who has a weakened immune system should be vaccinated. Women who plan to have children and are not immune should also be vaccinated. Adolescents (aged 13 and older) and adults need two doses of varicella vaccine for protection.
- If a person receives chickenpox vaccine within 3 days of being in contact with someone with chickenpox, there is a good chance they won't get sick.
- Some unvaccinated and nonimmune people (such as newborns, pregnant women, and people with weakened immune systems) who become exposed to chickenpox should get a shot of VZIG (instead of vaccine) to lower their chances of severe complications like pneumonia. This shot must be given less than 96 hours (four days) after exposure. VZIG offers only short-term protection, so anyone who gets it will still need to be vaccinated as described above in order to have long-term protection against chickenpox.
- State regulations require certain groups to be vaccinated against chickenpox. Susceptible children attending licensed day care or preschool, and those entering kindergarten, must show proof of receiving 1 dose of varicella vaccine or reliable proof of immunity. Those entering 7th grade must show proof of receiving 2 doses of varicella

vaccine or reliable proof of immunity. A reliable history is defined as 1) physician interpretation of parent/guardian description of chicken-pox; 2) phsyician diagnosis of chickenpox; or 3) serologic proof of immunity.

Should pregnant women worry about chickenpox?

Pregnant women who have already had chickenpox do not need to worry. Women who get chickenpox while they are pregnant are more likely than other adults to develop serious complications: the fetus can also be affected. Babies born to mothers with a current case of chickenpox can develop high fevers and other serious problems.

Pregnant women who have been exposed to somebody with chickenpox should see a doctor **immediately.** Those who are not sure if they had chickenpox as a child can have a blood test to see if they are protected against the virus. If not, they may need to get a shot of VZIG (varicella zoster immune globulin) to lower their chances of severe complications.

Can you get chickenpox more than once?

No. Once you have had chickenpox, you cannot get it again. However, the virus that causes chickenpox stays in your body the rest of your life. Years later it can give you a rash called shingles, which doctors call "herpes zoster." The shingles rash looks like chickenpox, but it usually shows up on only one part of your body and does not spread. Unlike chickenpox, shingles is painful. Children sometimes get shingles, but it is more common among adults. Touching fluid from the shingles rash can spread the virus that causes chickenpox to people who are not immune.

Is varicella vaccine safe?

Yes, it is safe for most people. However, a vaccine, like any medicine, is capable of causing problems like fever, mild rash, temporary pain or stiffness in the joints, and allergic reactions. More severe problems are very rare. About 70–90% of people who get the vaccine are protected from chickenpox. If vaccinated people do get chickenpox, it is usually very mild. They have a milder rash with fewer spots, lower fevers, and get better faster. They can still spread chickenpox to others who are not immune, but those contacts tend to have very mild disease as well.

Who should not get varicella vaccine?

- People who have serious allergies to gelatin, the drug neomycin, or a previous dose of the vaccine.
- Pregnant women should not get varicella vaccine until after they deliver their babies.
- People with cancer, HIV, or other problems that weaken the immune system should check with their doctor or nurse before being vaccinated.
- People who recently had a blood transfusion or were given other blood products should ask their doctor when they may get chickenpox vaccine.
- People with high fevers should not be vaccinated until after the fever and other symptoms are gone.

Where can you get more information?

- **Your doctor, nurse or clinic**
- **Your local board of health** (listed in the phone book under local government)
- **The Massachusetts Department of Public Health** (MDPH) Immunization Program at **(617) 983-6800** or toll-free at **1-888-658-2850**, or on the MDPH Website at **http://www.state.ma.us/dph/,** or the regional offices of the MDPH Immunization Program:

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November 1999

Alfred L. Frechette, M.D., M.P.H.
Commissioner

The Commonwealth of Massachusetts
Department of Public Health
600 Washington Street
Boston 02111

April 21, 1981

ADVISORY LETTER #118

TO: ADMINISTRATORS AND EMPLOYEES OF PUBLIC AND PRIVATE SCHOOLS, COLLEGES, UNIVERSITIES, AND SPECIAL TRAINING PROGRAMS FOR THE MENTALLY RETARDED OR YOUTHFUL OFFENDERS; BOARDS OF HEALTH AND HEALTH DEPARTMENTS

SUBJECT: 1981 AMENDMENT TO LAW REQUIRING SCREENING OF EDUCATIONAL PERSONNEL FOR TUBERCULOSIS, AND ADMINISTRATIVE GUIDELINES

On April 13, 1981, Governor Edward J. King signed into law an important amendment to Massachusetts General Law, Chap. 71, Sec. 55B, which required the examination and certification of all employees of schools, colleges, and other educational institutions to show freedom from tuberculosis in a communicable form. The new law will allow for a reduction in screening and x-ray exposure of educational personnel without loss of public protection, while at the same time resulting in significant cost savings to the Commonwealth and its cities and towns. As a result of action by the Governor to make this an emergency act, the law will have an effective date of April 13, 1981, rather than ninety days hence.

Enclosed are copies of the amended law, Chap. 71, Sec. 55B, and administrative guidelines.

Thomas J. Kearns

Thomas J. Kearns, Director
Division of Tuberculosis Control

Approved:

Alfred L. Frechette M.D.

COMMISSIONER

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF TUBERCULOSIS CONTROL
STATE LAB INSTITUTE
305 SOUTH STREET
JAMAICA PLAIN, MA 02130

Administrative Guidelines for Massachusetts General Law, Chapter 71, Section 55B, as Amended by Chapter 85, Acts of 1981, for Public and Private Schools, Colleges, Universities, and Special Training Programs for the Mentally Retarded or Youthful Offender.

EFFECTIVE APRIL 13, 1981

1. EMPLOYEES WHO HAVE PREVIOUSLY BEEN EXAMINED AND CERTIFIED IN MASSACHUSETTS AS FREE FROM TUBERCULOSIS IN A COMMUNICABLE FORM WILL NO LONGER BE REQUIRED TO BE RE-EXAMINED AND CERTIFIED ROUTINELY EVERY THREE YEARS.

   The educational institution should have on record that each employee has been issued a valid certification in Massachusetts.

2. ALL NEW EMPLOYEES MUST HAVE A SCREENING EXAMINATION AND BE CERTIFIED AS FREE FROM TUBERCULOSIS IN A COMMUNICABLE FORM BEFORE BEGINNING EMPLOYMENT IN MASSACHUSETTS.

   These employees must be screened by means of Mantoux tuberculin test unless known to be tuberculin positive.* If the test is negative, the employee may be certified. If the employee has a positive tuberculin test, a negative chest x-ray is required before certification.

3. EMPLOYEES WHO ARE EXPOSED TO A PATIENT WITH TUBERCULOSIS, AND EMPLOYEES WHO LIVE OR WORK IN AN AREA DETERMINED BY THE COMMISSIONER OF PUBLIC HEALTH TO BE A HIGH TUBERCULOSIS PREVALENCE AREA, MAY BE REQUIRED TO HAVE A REPEAT EXAMINATION AND CERTIFICATION TO SHOW FREEDOM FROM TUBERCULOSIS.

   At this time, no community or section thereof has been determined to be a high tuberculosis prevalence area.

4. EMPLOYEES WHO HAVE PREVIOUSLY FILED A VALID CERTIFICATION WITH ANOTHER EDUCATIONAL INSTITUTION IN MASSACHUSETTS, AND SUBSEQUENTLY TRANSFER EMPLOYMENT WITHIN THE COMMONWEALTH, SHALL NOT BE REQUIRED TO FILE A NEW CERTIFICATION.

Evidence of a valid certification should be transferred from the former to the new employer.

5. EMPLOYEES WHO HAVE BEEN CERTIFIED AS FREE FROM TUBERCULOSIS BY APPROVING AUTHORITIES OF OTHER STATES WHICH HAVE SIMILAR LAWS OR REGULATIONS REQUIRING CERTIFICATION MAY SUBMIT SUCH EVIDENCE FOR APPROVAL TO THE DIRECTOR OF THE DIVISION OF TUBERCULOSIS CONTROL.

6. ON PETITION IN WRITING, THE PROVISIONS OF THIS LAW MAY BE WAIVED BY THE DIRECTOR OF THE DIVISION OF TUBERCULOSIS CONTROL WHEN, IN HIS OPINION, OVEREXPOSURE TO RADIATION WOULD IMPERIL A PERSON'S HEALTH.

Persons applying for such waiver who have had a significant prior exposure to radiation, and those who have completed a medically approved course of preventive therapy should present such evidence in writing from their physician.

Standard card forms for the recording of certification (MDPH-T-36) are available from the Division of Tuberculosis Control. Syringes for tuberculin testing are also available from the Division. The testing agent, called "PPD, 5 TU" (Purified Protein Derivative, 5 tuberculin units) is available from the State Laboratory Institute, 305 South Street, Jamaica Plain, MA 02130. Telephone number is (617) 522-3700, extension 267. All of these items are available free of charge.

Administrators of educational programs should continue to be cognizant of their responsibilities for employee compliance with this law, and of their role in the prevention and control of tuberculosis in their institutions. No person known to be suffering from tuberculosis in a communicable form, or having evidence of symptoms thereof, shall be employed or continued in employment at such institution, whether or not such person has been previously certified as free from tuberculosis in a communicable form.

Thank you for your cooperation and assistance in the administration of this law and for your continued interest in the control and eradication of tuberculosis.

*See DPH Circular PH-TM 1321 (Adm. of a Tuberculin Test) Advisory Letter #100.

Thomas J. Kearns

Thomas J. Kearns, Director
Division of Tuberculosis Control

Approved:

Alfred L. Frechette M.D

COMMISSIONER

F/TCkm

Questions and Answers About TB

2002

CDC
TB Elimination

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SAFER • HEALTHIER • PEOPLE

Questions and Answers About TB

2002

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for HIV, STD, and TB Prevention
Division of Tuberculosis Elimination
January 2002

CONTENTS

For definitions of common terms related to TB, see the glossary at the back of this booklet (page 17).

INTRODUCTION

What is TB?

TB, or tuberculosis, is a disease caused by bacteria called *Mycobacterium tuberculosis.* The bacteria can attack any part of your body, but they usually attack the lungs. TB disease was once the leading cause of death in the United States.

In the 1940s, scientists discovered the first of several drugs now used to treat TB. As a result, TB slowly began to disappear in the United States. But TB has come back. Between 1985 and 1992, the number of TB cases increased. The country became complacent about TB and funding of TB programs was decreased. However, with increased funding and attention to the TB problem, we have had a steady decline in the number of persons with TB. But TB is still a problem; more than 16,000 cases were reported in 2000 in the United States.

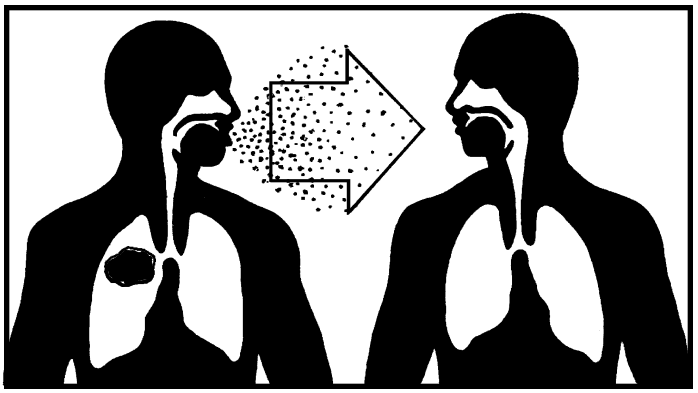
TB is spread through the air from one person to another. The bacteria are put into the air when a person with TB disease of the lungs or throat coughs or sneezes. People nearby may breathe in these bacteria and become infected.

People who are infected with **latent TB** do not feel sick, do not have any symptoms, and cannot spread TB. But they may develop **TB disease** at some time in the future. People with TB disease can be treated and cured if they seek medical help. Even better, people who have latent TB infection but are not yet sick can take medicine so that they will never develop TB disease.

This booklet answers common questions about TB. Please ask your doctor or nurse if you have other questions about latent TB infection or TB disease.

How is TB spread?

TB is spread through the air from one person to another. The bacteria are put into the air when a person with TB disease of the lungs or throat coughs or sneezes. People nearby may breathe in these bacteria and become infected.



When a person breathes in TB bacteria, the bacteria can settle in the lungs and begin to grow. From there, they can move through the blood to other parts of the body, such as the kidney, spine, and brain.

TB in the lungs or throat can be infectious. This means that the bacteria can be spread to other people. TB in other parts of the body, such as the kidney or spine, is usually not infectious.

People with TB disease are most likely to spread it to people they spend time with every day. This includes family members, friends, and coworkers.

What is latent TB infection?

In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. The bacteria become inactive, but they remain alive in the body and can become active later. This is called latent TB infection. People with latent TB infection:

- have no symptoms
- don't feel sick
- can't spread TB to others
- usually have a positive skin test reaction (see page 5)
- can develop TB disease later in life if they do not receive treatment for latent TB infection (see page 7)

Many people who have latent TB infection never develop TB disease. In these people, the TB bacteria remain inactive for a lifetime without causing disease. But in other people, especially people who have weak immune systems, the bacteria become active and cause TB disease.

What is TB disease?

TB bacteria become active if the immune system can't stop them from growing. The active bacteria begin to multiply in the body and cause TB disease. Some people develop TB disease soon after becoming infected, before their immune system can fight the TB bacteria. Other people may get sick later, when their immune system becomes weak for some reason.

Babies and young children often have weak immune systems. People infected with HIV, the virus that causes AIDS, have very weak immune systems. Other people can have weak immune systems, too, especially people with any of these conditions:

- substance abuse
- diabetes mellitus
- silicosis
- cancer of the head or neck
- leukemia or Hodgkin's disease
- severe kidney disease
- low body weight
- certain medical treatments (such as corticosteroid treatment or organ transplants)

Symptoms of TB depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs. TB in the lungs may cause:

- a bad cough that lasts longer than 2 weeks
- pain in the chest
- coughing up blood or sputum (phlegm from deep inside the lungs)

Other symptoms of TB disease are:

- weakness or fatigue
- weight loss
- no appetite
- chills
- fever
- sweating at night

For information on how TB disease is treated (see page 9).

Difference Between Latent TB Infection and TB Disease

Latent TB Infection	TB Disease
• Have no symptoms • Do not feel sick	• Symptoms include: - a bad cough that lasts longer than 2 weeks - pain in the chest - coughing up blood or sputum - weakness or fatigue - weight loss - no appetite - chills - fever - sweating at night
• Cannot spread TB to others	• May spread TB to others
• Usually have a positive skin test	• Usually have a positive skin test
• Chest x-ray and sputum tests normal	• May have abnormal chest x-ray, and/or positive sputum smear or culture

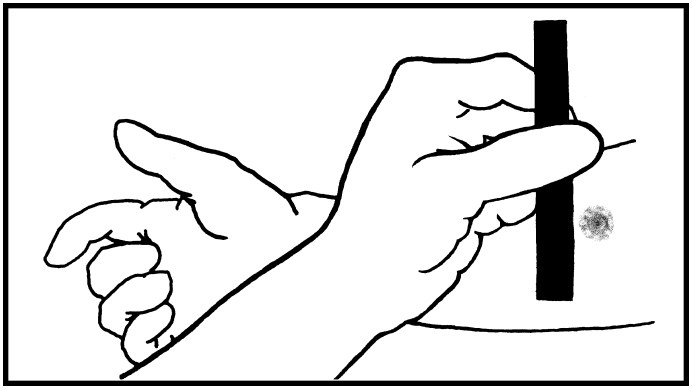
LATENT TB INFECTION

How can I get tested for TB?

A TB skin test is the only way to find out if you have latent TB infection. You can get a skin test at the health department or at your doctor's office. You should get tested for TB if:

- you have spent time with a person with known or suspected to have TB disease
- you have HIV infection or another condition that puts you at high risk for TB disease
- you think you might have TB disease
- you are from a country where TB disease is very common (most countries in Latin America and the Caribbean, Africa, Asia, Eastern Europe, and Russia)
- you inject drugs
- you live somewhere in the U.S. where TB disease is more common (homeless shelters, migrant farm camps, prisons and jails, and some nursing homes)

A health care worker can give you the TB skin test. The health care worker will inject a small amount of testing fluid (called tuberculin) just under the skin on the lower part of your arm. After 2 or 3 days, the health care worker will measure your reaction to the test. You



may have a small bump where the tuberculin was injected. The health care worker will measure this bump and tell you if your reaction to the test is positive or negative. A positive reaction usually means that you have latent TB infection.

If you have a positive reaction to the skin test, your doctor or nurse may do other tests to see if you have TB disease. These tests usually include a chest x-ray and a test of the phlegm you cough up. Because the TB bacteria may be found somewhere besides your lungs, your doctor or nurse may check your blood or urine, or do other tests. If you have TB disease, you will need to take medicine to cure the disease (see page 9).

If you have recently spent time with someone with infectious TB, your skin test reaction may not be positive yet. You may need a second skin test 10 to 12 weeks after the last time you spent time with the infectious person. This is because it can take several weeks after infection for your immune system to be able to react to the TB skin test. If your reaction to the second test is negative, you probably do not have latent TB infection.

What if I have been vaccinated with BCG?

BCG is a vaccine for TB. This vaccine is not widely used in the United States, but it is often given to infants and small children in other countries where TB is common. BCG vaccine does not always protect people from TB.

If you were vaccinated with BCG, you may have a positive reaction to a TB skin test. This reaction may be due to the BCG vaccine itself or to latent TB infection. But your positive reaction probably means that you have latent TB infection if:

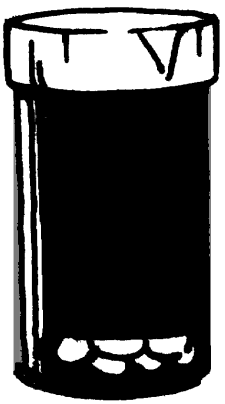
- you recently spent time with a person who has TB disease
- you are from an area of the world where TB disease is very common (most countries in Latin America and the Caribbean, Africa, Asia, Eastern Europe, and Russia)
- you spend time where TB is common (homeless shelters, drug-treatment centers, health care clinics, jails, prisons)

If I have latent TB infection, how can I keep from developing TB disease?

Many people who have latent TB infection never develop TB disease. But some people who have latent TB infection are more likely to develop TB disease than others. These people are at **high risk** for TB disease. They include:

- people with HIV infection
- people who became infected with TB bacteria in the last 2 years
- babies and young children
- people who inject drugs
- people who are sick with other diseases that weaken the immune system (see page 3)
- elderly people
- people who were not treated correctly for TB in the past

If you have latent TB infection (a positive skin test reaction) and you are in one of these high-risk groups, you need to take medicine to keep from developing TB disease. This is called treatment for latent TB infection. There are many treatment options. You and your health care provider must decide which treatment is best for you.



The medicine usually used for the treatment of latent TB infection is a drug called isoniazid or INH. INH kills the TB bacteria that are in the body. If you take your medicine as prescribed, treatment for latent TB infection will keep you from ever developing TB disease.

Most people must take INH for at least 6 to 9 months. Children and people with HIV infection may need to take INH for a longer time.

Sometimes people are given treatment for latent TB infection even if their skin test reaction is not positive. This is often done with infants, children, and HIV-infected people who have recently spent time with someone with infectious TB disease. This is because they are at very high risk of developing serious TB disease soon after they become infected with TB bacteria.

It is important that you take all the pills prescribed for you so that your treatment for latent TB infection is effective. If you start taking INH, you will need to see your doctor or nurse on a regular schedule. He or she will check on how you are doing. Very few people have serious side effects to INH. However, if you have any of the following side effects, call your doctor or nurse right away:

- no appetite
- nausea
- vomiting
- yellowish skin or eyes
- fever for 3 or more days
- abdominal pain
- tingling in the fingers and toes

Warning: Drinking alcoholic beverages (wine, beer, and liquor) while taking INH can be dangerous. Check with your doctor or nurse for more information.

People who have latent TB infection but do not receive treatment for latent TB infection need to know the symptoms of TB. If they develop symptoms of TB disease later on, they should see a doctor right away.

What if I have HIV infection?

A person can have latent TB infection for years without any signs of disease. But if that person's immune system gets weak, the infection can quickly turn into TB disease. Also, if a person who has a weak immune system spends time with someone with infectious TB, he or she may become infected with TB bacteria and quickly develop TB disease.

Because HIV infection weakens the immune system, people with latent TB infection and HIV infection are at **very high risk** of developing TB disease. All HIV-infected people should be given a TB skin test to find out if they have latent TB infection. If they have latent TB infection, they need treatment for latent TB infection **as soon as possible** to prevent them from developing TB disease. If they have TB disease, they must take medicine to cure the disease.

TB disease can be prevented and cured, even in people with HIV infection.

TB DISEASE

How is TB disease treated?

There is good news for people with TB disease! TB disease can almost always be cured with medicine. But the medicine must be taken as the doctor or nurse tells you.

The most common drugs used to fight TB are:

- isoniazid (INH)
- rifampin
- pyrazinamide
- ethambutol
- streptomycin

If you have TB disease, you will need to take several different drugs. This is because there are many bacteria to be killed. Taking several drugs will do a better job of killing all of the bacteria and preventing them from becoming resistant to the drugs.

If you have TB of the lungs or throat, you are probably infectious. You need to stay home from work or school so that you don't spread TB bacteria to other people. After taking your medicine for a few weeks, you will feel better and you may no longer be infectious to others. Your doctor or nurse will tell you when you can return to work or school.

Having TB should not stop you from leading a normal life. When you are no longer infectious or feeling sick, you can do the same things you did before you had TB. The medicine that you are taking should not affect your strength, sexual function, or ability to work. If you take your medicine as your doctor or nurse tells you, the medicine will kill all the TB bacteria. This will keep you from becoming sick again.

What are the side effects of drugs for TB?

Medicine for TB is relatively safe. Occasionally, the drugs may cause side effects. Some side effects are minor problems. Others are more serious. If you have a serious side effect, **call your doctor or nurse immediately**. You may be told to stop taking your medicine or to return to the clinic for tests.

The side effects listed below are **serious**. If you have any of these symptoms, call your doctor or nurse immediately:

- no appetite
- nausea
- vomiting
- yellowish skin or eyes
- fever for 3 or more days
- abdominal pain
- tingling fingers or toes
- skin rash
- easy bleeding
- aching joints
- dizziness
- tingling or numbness around the mouth
- easy bruising
- blurred or changed vision
- ringing in the ears
- hearing loss

The side effects listed below are **minor** problems. If you have any of these side effects, you can continue taking your medicine:

- Rifampin can turn urine, saliva, or tears orange. The doctor or nurse may advise you not to wear soft contact lenses because they may get stained.

- Rifampin can make you more sensitive to the sun. This means you should use a good sunscreen and cover exposed areas so you don't burn.

- Rifampin also makes birth control pills and implants less effective. Women who take rifampin should use another form of birth control.

- If you are taking rifampin as well as methadone (used to treat drug addiction), you may have withdrawal symptoms. Your doctor or nurse may want to adjust your methadone dosage.

Why do I need to take TB medicine regularly?

TB bacteria die very slowly. It takes at least 6 months for the medicine to kill all the TB bacteria. You will probably start feeling well after only a few weeks of treatment. But beware! The TB bacteria are still alive in your body. You must continue to take your medicine until all the TB bacteria are dead, even though you may feel better and have no more symptoms of TB disease.

If you don't continue taking your medicine or you aren't taking your medicine regularly, this can be very dangerous. The TB bacteria will grow again and you will remain sick for a longer time. The bacteria may also become resistant to the drugs you are taking. You may need new, different drugs to kill the TB bacteria if the old drugs no longer work. These new drugs must be taken for a longer time and usually have more serious side effects.

If you become infectious again, you could give TB bacteria to your family, friends, or anyone else who spends time with you. It is **very important** to take your medicine the way your doctor or nurse tells you.

How can I remember to take my medicine?

The only way to get well is to take your medicine exactly as your doctor or nurse tells you. This may not be easy! You will be taking your medicine for a long time (6 months or longer), so you should get into a routine. Here are some ways to remember to take your medicine:

- Participate in the directly observed therapy (DOT) program at your health department.
- Take your pills at the same time every day — for example, you can take them before eating breakfast, during a coffee break, or after brushing your teeth.
- Ask a family member or a friend to remind you to take your pills.
- Mark off each day on a calendar as your take your medicine.
- Put your pills in a weekly pill dispenser. Keep it by your bed or in your purse or pocket.

NOTE: Remember to keep all medicine out of reach of children.

If you forget to take your pills one day, skip that dose and take the next scheduled dose. Tell your doctor or nurse that you missed a dose. You may also call your doctor or nurse for instructions.

The best way to remember to take your medicine is to get directly observed therapy (DOT). If you get DOT, you will meet with a health care worker every day or several times a week. You will meet at a place you both agree on. This can be the TB clinic, your home or work, or any other convenient location. You will take your medicine at this place.

DOT helps in several ways. The health care worker can help you remember to take your medicine and complete your treatment. This means you will get well as soon as possible. With DOT, you may need to take medicine only 2 or 3 times each week instead of every day.

The health care worker will make sure that the medicine is working as it should. This person will also watch for side effects and answer questions you have about TB.

Even if you are not getting DOT, you must be checked at different times to make sure everything is going well. You should see your doctor or nurse regularly while you are taking your medicine. This will continue until you are cured.

How can I keep from spreading TB?

The most important way to keep from spreading TB is to take all your medicine, exactly as directed by your doctor or nurse. You should also keep all of your clinic appointments! Your doctor or nurse needs to see how you are doing. You may need another chest x-ray or a test of the phlegm you may cough up. These tests will show whether the medicine is working. They will also show whether you can still give TB bacteria to others. Be sure to tell the doctor about anything you think is wrong.

If you are sick enough with TB to go to a hospital, you may be put in a special room. These rooms use air vents that keep TB bacteria from spreading. People who work in these rooms must wear a special face mask to protect themselves from TB bacteria. You must stay in the room so that you will not spread TB bacteria to other people. Ask a nurse if you need anything that is not in your room.

If you are infectious while you are at home, there are certain things you can do to protect yourself and others near you. Your doctor may tell you to follow these guidelines to protect yourself and others:

- The most important thing is to take your medicine.
- Always cover your mouth with a tissue when you cough, sneeze, or laugh. Put the tissue in a closed paper sack and throw it away.
- Do not go to work or school. Separate yourself from others and avoid close contact with anyone. Sleep in a bedroom away from other family members.

- Air out your room often to the outside of the building (if it is not too cold outside). TB spreads in small closed spaces where air doesn't move. Put a fan in your window to blow out (exhaust) air that may be filled with TB bacteria. If you open other win dows in the room, the fan also will pull in fresh air. This will reduce the chances that TB bacteria stay in the room and infect someone who breathes the air.

Remember, TB is spread through the air. People cannot get infected with TB bacteria through handshakes, sitting on toilet seats, or sharing dishes and utensils with someone who has TB.

After you take medicine for about 2 or 3 weeks, you may no longer be able to spread TB bacteria to others. If your doctor or nurse agrees, you will be able to go back to your daily routine. Remember, you will get well only if you take your medicine exactly as your doctor or nurse tells you.

Think about people who may have spent time with you, such as family members, close friends, and coworkers. The local health department may need to test them for latent TB infection. TB is especially dangerous for children and people with HIV infection. If infected with TB bacteria, these people need preventive therapy right away to keep from developing TB disease.

What is multidrug-resistant TB (MDR TB)?

When TB patients do not take their medicine as prescribed, the TB bacteria may become resistant to a certain drug. This means that the drug can no longer kill the bacteria. Drug resistance is more common in people who:

- have spent time with someone with drug-resistant TB disease
- do not take their medicine regularly
- do not take all of their prescribed medicine
- develop TB disease again, after having taken TB medicine in the past
- come from areas where drug-resistant TB is common

Sometimes the bacteria become resistant to more than one drug. This is called multidrug-resistant TB, or MDR TB. This is a **very serious** problem. People with MDR TB disease must be treated with special drugs. These drugs are not as good as the usual drugs for TB and they may cause more side effects. Also, some people with MDR TB disease must see a TB expert who can closely observe their treatment to make sure it is working.

People who have spent time with someone sick with MDR TB disease can become infected with TB bacteria that are resistant to several drugs. If they have a positive skin test reaction, they may be given preventive therapy. This is **very important** for people who are at high risk of developing MDR TB disease, such as children and HIV-infected people.

GLOSSARY OF TERMS RELATED TO TB

BCG - a vaccine for TB named after the French scientists Calmette and Guérin. BCG is not widely used in the United States, but it is often given to infants and small children in other countries where TB is common.

Cavity - a hole in the lung where TB bacteria have eaten away the surrounding tissue. If a cavity shows up on your chest x-ray, you are more likely to cough up bacteria and be infectious.

Chest x-ray - a picture of the inside of your chest. A chest x-ray is made by exposing a film to x-rays that pass through your chest. A doctor can look at this film to see whether TB bacteria have damaged your lungs.

Contact - a person who has spent time with a person with infectious TB.

Culture - a test to see whether there are TB bacteria in your phlegm or other body fluids. This test can take 2 to 4 weeks in most laboratories.

Directly observed therapy (DOT) - a way of helping patients take their medicine for TB. If you get DOT, you will meet with a health care worker every day or several times a week. You will meet at a place you both agree on. This can be the TB clinic, your home or work, or any other convenient location. You will take your medicine at this place.

Extrapulmonary TB - TB disease in any part of the body other than the lungs (for example, the kidney or lymph nodes).

HIV infection - infection with the human immunodeficiency virus, the virus that causes AIDS (acquired immunodeficiency syndrome). A person with both latent TB infection and HIV infection is at very high risk for TB disease.

Infectious TB - TB disease of the lungs or throat, which can be spread to other people.

Infectious person - a person who can spread TB to others because he or she is coughing TB bacteria into the air.

INH or isoniazid - a drug used to prevent TB disease in people who have latent TB infection. INH is also one of the 5 drugs often used to treat TB disease.

Latent TB infection - a condition in which TB bacteria are alive but inactive in the body. People with latent TB infection have no symptoms, don't feel sick, can't spread TB to others, and usually have a positive skin test reaction. But they may develop TB disease later in life if they do not receive treatment for latent TB infection.

Miliary TB - TB disease that has spread to the whole body through the bloodstream.

Multidrug-resistant TB (MDR TB) - TB disease caused by bacteria resistant to more than one drug often used to treat TB.

***M. tuberculosis* -** bacteria that cause latent TB infection and TB disease.

Negative - usually refers to a test result. If you have a negative TB skin test reaction, you probably **do not have** latent TB infection.

Positive - usually refers to a test result. If you have a positive TB skin test reaction, you probably **have** latent TB infection.

Pulmonary TB - TB disease that occurs in the lungs, usually producing a cough that lasts longer than 2 weeks. Most TB disease is pulmonary.

Resistant bacteria - bacteria that can no longer be killed by a certain drug.

TB skin test - a test that is often used to detect latent TB infection. A liquid called tuberculin is injected under the skin on the lower part of your arm. If you have a positive reaction to this test, you probably have latent TB infection.

Treatment for latent TB infection - treatment for people with latent TB infection that prevents them from developing TB disease.

Smear - a test to see whether there are TB bacteria in your phlegm. To do this test, lab workers smear the phlegm on a glass slide, stain the slide with a special stain, and look for any TB bacteria on the slide. This test usually takes 1 day.

Sputum - phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using a smear; part of the sputum can also be used to do a culture.

TB disease - an illness in which TB bacteria are multiplying and attacking different parts of the body. The symptoms of TB disease include weakness, weight loss, fever, no appetite, chills, and sweating at night. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs (pulmonary TB), the symptoms may include a bad cough, pain in the chest, and coughing up blood.

Tuberculin - a liquid that is injected under the skin on the lower part of your arm during a TB skin test. If you have latent TB infection, you will probably have a positive reaction to the tuberculin.

This publication is available free of charge and can be requested in the following ways:

- Through the DTBE's online ordering system: www.cdc.gov/nchstp/tb
- Through CDC's Voice and Fax Information System by calling toll free: 1-888-232-3228 and requesting *Questions and Answers About Tuberculosis*, publication order #00-6469.

Early Intervention Program Facility Checklist
Department of Public Health

Program _____ Location _____

Regional Specialist _____ Visit Date _____

Is program currently licensed by OCCS? Yes ___ No ___ If yes, license expiration date _____

If license is current, complete Section VI and Section VII, # 5 only.
If no, is there OCCS documentation stating only occasional care will be provided? Yes ___ No ___

I. - SPACE

01. ___ There is adequate space for each child and adult present.
02. ___ The play space is well ventilated and free of cigarette smoke.
03. ___ There is a comfortable, non-intrusive space where parents & visitors can observe play groups.
04. ___ There is a nearby outdoor play space.
05. ___ There is a place where adults can have a meeting.
06. ___ There is a place where two adults can have a private conference.
07. ___ Each full time staff person has an individual workspace.
08. ___ There is adequate storage for play group materials & equipment.

II. - SAFETY

01. ___ There is an evacuation plan posted visibly in each room.
02. ___ Staff is familiar with the evacuation plan.
03. ___ Every staff person has participated in an evacuation drill.
04. ___ There is an evacuation drill within the first 3 weeks of each play group session.
05. ___ The exit from each room is clearly marked.
06. ___ Each exit is clear of obstructions.
07. ___ Furniture is free of hazards.
08. ___ Walls and floors are free of hazards.
09. ___ Hot surfaces and hot water appliances are inaccessible to children.
10. ___ Children's areas are free of dangling electrical cords.
11. ___ All hazardous substances are inaccessible to children.
12. ___ All areas are free of choking hazards.
13. ___ All arts & crafts materials are safe.
14. ___ The outdoor play area and route to it is protected from traffic.
15. ___ The outdoor play area is free of broken glass, hazards.
16. ___ The outdoor play equipment is safe.
17. ___ Fire extinguishers are visible. ___ accessible ___ charged
18. ___ Smoke detectors are present.
19. ___ An automatic sprinkler system is present.

III. - SANITATION

01. ___ There is a place for hand washing.
02. ___ Hand washing procedures are posted.
03. ___ There are appropriate cleaning and housekeeping materials.
04. ___ Clean-up areas are separate from food handling and toileting areas.
05. ___ Water play containers and toys are sanitized daily.
06. ___ All toys and play materials are washable.
07. ___ All toys and play materials are clean.
08. ___ All stored foods are covered and refrigerated.
09. ___ All food handling areas (including refrigerator) are clean.

IV. - TOILETING AND DIAPERING

01. ___ All toileting and diapering areas are separate from food handling areas.
02. ___ There is running water in the toileting area.
03. ___ There is running water in the diapering area.
04. ___ There are disinfecting materials, stored safely, in these areas.
05. ___ There is a disposable diapering surface.
06. ___ There is a covered, lined trash container for soiled diapers.
07. ___ Potty chairs are clean and disinfected.
08. ___ A diapering plan is posted.

V. - EMERGENCIES/FIRST AID

01. ___ There is a well-stocked, accessible first aid kit.
02. ___ There is a staff person certified in first aid and CPR on site when children are present.
03. ___ There is a list of emergency phone numbers by each phone.
04. ___ The list includes the MA Poison Information Center.
05. ___ There is an emergency number for every child whose caregiver is not present.
06. ___ There is an emergency number for caregivers who are present.
07. ___ All staff are aware of special medical needs/allergies of children present.
08. ___ There is an allergy precaution list posted.
09. ___ There is a telephone/intercom system readily accessible for emergencies.

VI. - TRANSPORTATION

01. ___ The transportation drop off point is:
    ___ off street with loading/unloading zone.
    ___ on street with enforced designated parking space for handicapped loading/unloading.
02. ___ There is adequate, interior/protected, secure storage space for car seats.
03. ___ The car seat storage space is readily accessible to drivers.
04. ___ The drop off point is within view of program staff or there is a system for drivers to communicate (i.e., buzzer)
05. ___ Staff meet transportation vehicles at the drop off point.
06. ___ Transportation concerns are promptly reported.

VII. - OTHER

01. ___ There is a current Building Certificate of Inspection from the local building inspector posted or on file.
02. ___ There is a document on file that certifies the facility was inspected for lead and was found to be in compliance
with Massachusetts General Law, Chapter 111, Section 197, and 105 CMR 460.000.
Date of inspection: _____ OR 02a. ___ There is documentation the facility was built after 1978.
03. ___ The facility appears to be asbestos-safe.
04. ___ The facility meets the criteria for accessibility as listed in the Rules and Regulations of the Architectural Access Board (521 CMR) or by compliance with the requirements of OCCS (102 CMR 7.11 [15]-[24]).
05. ___ All areas (including bathrooms) are accessible to the following:
___ children
___ caregivers
___ staff
06. ___ Attach a current list of staff and consultants with a copy of license (where applicable) for each. Include first aid and CPR certification, proof of negative TB test and documentation that person was in good health at the time of hire.

Community Group Facility Approval Form

Required for facilities <u>when caregivers will not be present</u> – Program will submit this form and documentation to the Regional Early Intervention Specialist who, upon approval, will forward copies to the EI Transportation office and to the appropriate RTA.

The facility _____ located at
(Name of Facility)

_____ is approved
(Street Address)

for the provision of MDPH Early Intervention services.

There are two methods for facility approval:

☐ A.1. Copy of current licensure by the Office of Child Care Services (OCCS)

☐ A.2. If needed, evidence of provisional certification of staff for community EI provider.

OR

☐ B.1. Current Building Certificate of Inspection which indicates "Code I-2" and "Code E" Usage.

☐ B.2. Documentation that the building is lead safe.

☐ B.3. Documentation that the facility meets the criteria for accessibility **of at least one site** as listed in the Rules and Regulations of the Architectural Access Board (521 CMR) or by compliance with the requirements of OCCS (102 CMR. 7.11 [15]-[24]).

☐ B.4. The MDPH Early Intervention Facility Checklist has been completed. (Allow 2 weeks to schedule a visit).

AND (for both methods):

☐ EI program staff have reviewed the MDPH Early Intervention Transportation Standards with the Facility staff and they have agreed to comply (see page 2 of this document for details).

_____ _____
(Program Director) (Date)

This section to be completed by Regional EI Specialist: Transportation code ☐☐☐☐☐

☐ Copies forwarded to Director, EI Transportation Services and to RTA. _____
(Date)

_____ _____
(Regional Early Intervention Specialist) (Date)

The requirement for facility staff to comply with transportation standards is directly related to the safety and security of the children being transported. The following are some of these Standards (please refer to your EI Transportation Standards for a complete listing):

- Facility staff must be available for one hour before and after any scheduled session involving EI transportation. This requirement may be satisfied with the EI program staff from the primary site being available in lieu of staff from a community facility.
- The facility must be accessible (preferably off street parking) for the safe loading and discharging of children to and from the vehicle.
- Facility staff are required to go out to the vehicle and help children entering and exiting the vehicle and assist in securing and releasing children in car seats and seat belts. Drivers are required to participate in this process and must check to insure all children and passengers are properly secured.
- Facility staff must verify and sign Trip/route sheets and forward them to EI program staff.
- The facility must have adequate storage space for children's car seats (car seats do not stay on the vehicle).
- Facility staff must report any issues or problems with transportation to EI program staff.

First Aid Kits

Recommendations taken from Caring for Our Children: National Health and Safety Performance Standards, Chapter 5: Facilities, page 226

Each kit shall be a closed container for storing first aid supplies, accessible to child care staff members at all times but out of reach of children. First aid kits shall be restocked after use, and an inventory shall be conducted at least monthly. The first aid kit shall contain at least the following items:

a) Disposable nonporous gloves;
b) Scissors;
c) Tweezers;
d) A non-glass, non-mercury thermometer to measure a child's temperature;
e) Bandage tape;
f) Sterile gauze pads;
g) Flexible roller gauze;
h) Triangular bandages;
i) Safety pins;
j) Eye dressing;
k) Pen/pencil and note pad;
l) Syrup of ipecac (use only if recommended by the Poison Control Center);
m) Cold pack;
n) Current American Academy of Pediatrics (AAP) standard first aid chart or equivalent first aid guide;
o) Coins for use in a pay phone;
p) Water;
q) Small plastic or metal splints;
r) Liquid soap;
s) Adhesive strip bandages, plastic bags for clothes, gauze, and other materials used in handling blood;
t) Any emergency medication needed for children with special needs;
u) List of emergency phone numbers, parents' home and work phone numbers, and the Poison Control Center phone number.

GCC/SACC ILLNESS/INJURY REPORT FORM

CENTER_____ FACILITY ID#_____
ADDRESS _____
Administrator_____

Child's Name _____ Date of Birth _____
Parent's name _____ Home Telephone _____

Date, time and location of illness/injury _____
Where did injury occur? _____
Description of illness/injury: how did it happen? _____

Who assessed the illness/injury? _____
Who administered first aid or CPR? _____
What first aid was administered? _____

Was 911 called? _____
Was child transported for medical attention? _____ Where? _____By Whom?_____
What treatment was provided? _____
Diagnosis of child _____
What group was child in when illness/injury occurred?_____ Number of children in group?_____
Name & qualification of staff who were supervising the group when illness/injury occurred? _____

Name(s) of witness(es) _____
Describe equipment involved, if applicable (location, condition...) _____

Was parent notified? _____ How? _____ When? _____ By whom? _____
Was a 51A filed? _____

Additional Information _____

I hereby certify that the above information is true and accurate.

Signature and Position of Person Completing Form Date

Signature of Parent Date
(optional but recommended)

To submit to OCCS within 3 business days if child receives medical attention

____ Placed in Child's file
____ Entered in Central Log or File
____ Copy provided to parent

____ GCC/SACC Injury Report Form
____ Hospital report, if applicable
____ Copy of First Aid cards for staff involved

ILLNESS/INJURY LOG

CHILD'S NAME	GROUP	DESCRIPTION OF ILLNESS/INJURY	DATE & TIME OF ILLNESS/INJURY	LOCATION WHERE INJURY OCCURRED	CAUSE OF INJURY	EQUIP/PRODUCT INVOLVED

EXHIBIT 7-2

SAMPLE INDIVIDUALIZED HEALTH CARE PLAN (IHCP)
HEALTH CARE PLAN FOR THE SCHOOL SETTING

_____ (Health Care Coordinator)

_____ (Education Coordinator)

Student Information:

_____ (Name) _____ (Birthdate)

_____ (Grade)

_____ (School)

_____ (Parent/Guardian) _____ (Address)

Mother (___) _____ (home) (___) _____ (work)

Father (___) _____ (home) (___) _____ (work)

Preparation for Entry/Development of Health Care Plan

☐ Home Assessment _____ (Date) by _____ (Name, Title)

Summary _____ (Date) Parent Interview _____ (Date)

Student Interview _____ (when appropriate) (Date)

☐ Medical History _____ (Date)

☐ Planning Meetings _____ (Date) _____ (Date) _____ (Date)

☐ Staff Training Meetings _____ (Date) _____ (Date) _____ (Date)

☐ Educ. Team Meeting _____ (Date) _____ (Date) _____ (Date)

Doctor's Order _____ (Date)

Parent's Consent _____ (Date)

Child-Specific Procedural Guidelines _____ (Date)

Emergency Plan _____ (Date)

Health Care Plan Included in Child's Record _____ (Date)

Child-Specific Care-giver Training (Skills Checklist) _____ (Date)

Next Training Review _____ (Date)

Health Care Plan Included in IEP: _____ (Date)

Next Review of Health Care Plan _____ (Date)

KEY CONTACTS

Name_____ Date_____

Primary Health Care Providers	Telephone Numbers

School Contacts

	Training	
Direct Caregivers	Child-Specific	General
Substitute Caregivers		
Back-up Staff		

Child-Specific Training Done By

_____ _____
(Date)

General Staff Training Done By

_____ _____
(Date)

Supervision Provided By

_____ _____
(Frequency)

[Used with permission of Project School Care, Children's Hospital, Boston, MA.]

PLAN FOR SPECIFIC PROCEDURE

Name _____ Date _____

Procedure: _____

Frequency: _____ Times: _____

Position of student during procedure: _____

Ability of the student to assist/perform procedure: _____

_____

Suggested setting for procedure: _____

Equipment:

Daily: _____ Emergency: _____

Checked by: _____ Checked by: _____

Storage: _____ Storage: _____

Maintenance: _____ Maintenance: _____

Home Care Co.: _____ Phone: _____

Child-specific techniques and helpful hints:

_____

Special considerations and precautions:

_____

[Used with permission of Project School Care, Children's Hospital, Boston, MA.]

LICENSED PROVIDER'S ORDER FOR SPECIALIZED HEALTH CARE PROCEDURE

Student's Name: _____ Birthdate: _____

Address: _____

Procedure: _____

_____

☐ I have reviewed the Health Care Plan and approve of it as written.

☐ I have reviewed the Health Care Plan and approve of it with the attached amendments.

☐ I do not approve of the Health Care Plan. A substitute plan is attached.

Other recommendations:

_____

_____

_____

_____

_____

_____

_____

Duration of the Procedure:

_____

(Date)

Physician's Signature: _____

Date: _____

Address: _____

_____ Phone: _____

[Adapted with permission from: *Pupil Personnel Services. Recommended Practices and Procedures Manual.* Illinois State Board of Education. 1983.]

POSSIBLE PROBLEMS

Name _____ Date _____

Observation	Reason	Action

[Used with permission of Project School Care, Children's Hospital, Boston, MA.]

EMERGENCY PLAN

Name:_____ Date:_____

Child-Specific Emergencies:

If You See This	Do This

If an emergency occurs:

1. Stay with the child.
2. Call or designate someone to call the nurse.

   State who you are:

   State where you are:

   State problem:

3. The school nurse will assess the child and decide whether the emergency plan should be implemented.
4. If the school nurse is unavailable, the following staff members are trained to deal with an emergency and to initiate the emergency plan:

_____

_____

_____

_____

[Used with permission of Project School Care, Children's Hospital, Boston, MA.]

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name _____

Date of Birth / / **Sex:** ☐ female ☐ male

Vaccine				Date
Hepatitis B			1	
			2	
			3	
DTaP	DT	Td	1	
			2	
			3	
			4	
			5	
			6	
			7	
IPV			1	
			2	
			3	
			4	
PCV7 (Pneumococcal conjugate 7-valent)			1	
			2	
			3	
			4	

Vaccine		Date
Hib	1	
	2	
	3	
	4	
MMR	1	
	2	
Varicella	1	
	2	
Hepatitis A	1	
	2	
PPV23 (Pneumococcal polysaccaride 23-valent)	1	
	2	
Influenza	1	
	2	
	3	
Other:		

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also ✓ Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature: _____

Facility name: _____

PUBLIC HEALTH FACT SHEET

Salmonellosis from Reptiles

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is salmonellosis from reptiles?

All reptiles (lizards, snakes, and turtles) carry an infectious bacteria (germ) called *salmonella*. Salmonellosis is the disease caused by this bacteria.

What are the symptoms of salmonellosis in people?

Salmonellosis can cause an upset stomach, cramps, diarrhea, fever, nausea, and vomiting. Symptoms can take up to three days to show up, but most people get sick 12 to 36 hours after the germs are swallowed. Symptoms usually last for several days. Some people may get sick enough to go to the hospital. In rare cases, the bacteria can get into the blood and become life-threatening.

Who is at risk?

Salmonellosis can be very dangerous for infants, children, pregnant women, and the elderly. This disease is also dangerous for people who can not fight this bacteria because they may have a weakened immune system from HIV/AIDS, cancer or chemotherapy, organ transplants, kidney failure, chronic liver problems, or other diseases.

Will my pet reptile have any symptoms?

No. Salmonellosis does not usually make reptiles sick. They can have this bacteria and not have diarrhea or any other problems; however, they can still shed the bacteria in their feces.

How is salmonellosis spread?

Reptiles shed the bacteria in their feces. Since most reptiles are kept in a cage or aquarium, they are likely to have feces on their skin. They then spread the feces around the entire cage. People who touch their pets or clean the cages may get feces on their hands. They may then touch their hands to their face or mouths when eating, smoking, scratching, or biting their nails. Touching food may spread the feces from a person's hands to his or her mouth. If people do not wash their hands, the bacteria gets into their mouths and is swallowed. An infected person can also spread the bacteria to other people through his or her own feces.

How can salmonellosis be prevented?

Always wash your hands after touching a reptile or cleaning its cage.
Keep reptiles away from kitchens and food.
Never wash a reptile in a kitchen sink, bathroom sink, or bathtub.
Prevent infants, children, the elderly, and people with weakened immune systems from touching the pet or its cage. It is also important to keep those people away from areas where the reptile has been.

Can salmonellosis be treated?

Salmonellosis in people is usually not treated unless someone goes to the hospital. Reptiles should not be treated with antibiotics. This bacteria is normal for them.

Where can I get more information?

Salmonellosis in Humans: **The Massachusetts Department of Public Health**, Division of Epidemiology and Immunization **(617) 983-6800** or toll-free at **1-888-658-2850** or on the MDPH website at **http://www.state.ma.us/dph**

(OVER)

Salmonellosis in animals: **The Department of Food and Agriculture,** Bureau of Animal Health **(617) 727-3018.**

Your local board of health (listed in the phone book under local government)

Your doctor, nurse or health center

April 1997

Child Care Health and Safety Advisory

brought to you by the
Massachusetts Department of Public Health and the
Massachusetts Office for Child Care Services

BUREAU of COMMUNICABLE DISEASE CONTROL • *Division of Epidemiology and Immunization*
BUREAU of FAMILY AND COMMUNITY HEALTH • *Division of Maternal, Child and Family Health*
MAX CARE • *MAXIMIZING THE HEALTH AND SAFETY OF CHILDREN IN OUT-OF-HOME CARE*

Spring 2001

PRECAUTIONS CONCERNING REPTILES IN CHILD CARE SETTINGS

The Massachusetts Department of Public Health recommends that programs serving young children develop policies prohibiting reptiles (lizards, snakes and turtles) from coming in contact with infants. toddlers and preschoolers. Programs serving children older than five years of age should develop policies concerning reptiles. These policies would require strict handwashing and additional precautions for protecting children and staff with compromised immune systems.

Anyone who has contact with a reptile or its housing is at risk of getting *salmonellosis*. Infants and young children are the most commonly affected. Pregnant women, the elderly, and people with compromised immune systems are also at risk. Currently three states (Arizona, Minnesota and Wyoming) prohibit reptiles in day care centers.

What is salmonellosis?
Salmonellosis is an infection occurring after the ingesting any of the many types of Salmonella bacteria. Salmonella infection usually causes diarrhea, vomiting, fever, and cramping. In severe cases, it can lead to hospitalization. Salmonella can be found in uncooked foods such as eggs or raw chicken and in animal and human feces.

Why precautions regarding reptiles?
All reptiles shed Salmonella bacteria in their feces at some point. The reptiles don't usually show signs of disease. These bacteria are normal inhabitants of the gut of lizards, snakes, and turtles. The bacteria spread inside cages, tanks, and on the skin of the reptiles.

Reptiles should not be treated with antibiotics, since this will not likely affect the salmonella in their intestines and it may promote resistant bacteria. In addition, reptiles should not be tested for salmonella because they shed it intermittently. A negative test is probably meaningless.

Salmonella bacteria are spread easily from the reptile or its housing. When people touch an infected area, the bacteria get on their hands. When the infected hand touches a mouth, the bacteria are swallowed and can cause disease. Indirect contact can also cause illness. Contact with a floor or surface where a reptile has walked can be a source, or eating food prepared by someone who may have had contact and has not washed his or her hands properly.

What are the recommendations that apply to child care providers?

- **Children 5 years old and younger should avoid all direct contact with reptiles or materials in contact with reptiles.**

Develop a policy statement <u>immediately</u> prohibiting lizards, snakes, and turtles from infant. toddler, and preschool classrooms.

- **Pet reptiles should be kept out of households where children age 1 year and younger may live or be cared for.**

Family child care homes should not have lizards. snakes, and turtles.

- **Pet reptiles should not be kept in child care centers.**

Group child care and preschools should prohibit lizards. snakes, and turtles.

- School age programs should establish and maintain clear reptile policies immediately.

1. Reptiles should not be allowed to roam freely.
2. Reptiles should be kept out of kitchens and other food-preparation areas to prevent contamination.
3. Kitchen sinks should not be used to bathe reptiles or to wash their dishes, cages, or aquariums. If bathtubs are used for these purposes, they should be cleaned thoroughly and disinfected with bleach.
4. Require strict handwashing procedures. Persons should always wash their hands thoroughly with soap and water after handling reptiles or reptile cages.
5. School age programs should consider not keeping reptiles if immune compromised individuals are in the programs.
6. Immune compromised individuals in school age programs with reptiles should
    a. not be allowed to handle reptiles or reptile cages,
    b. not be in physical contact with others who have handled reptiles or reptile cages until after those others wash their hands,
    c. avoid areas (floors and other surfaces) where reptiles have walked until after those areas have been cleaned and disinfected,
    d. thoroughly wash their hands and any other body parts if they accidentally come into contact with a reptile,
    e. avoid any physical contact with others in child care settings who have diarrheal illness, and
    f. contact a health care provider (HCP) if they develop diarrheal illness, and have the individual or a parent or guardian explain to the HCP that reptiles are kept in an environment where the individual spends time.
7. Parents/guardians of immune compromised children in school age programs with reptiles should be informed of the risks to their children and be given a copy of this health care advisory so they can help their children to learn appropriate precautionary behaviors.

Office of Child Care Services Regulations:
Child care programs should review the OCCS licensing regulations listed below which have requirements that support this DPH advisory.

Family Child Care
8.08 Physical Facility Requirements
8.11 Supervision
8.12 Program Activities and Equipment
8.13 Comfort and Welfare of Children

Group Day Care
7.05 Required Policies
7.22 Supervision
7.23 Curriculum, Activities, and Equipment
7.25 Physical Facility Requirements

School Age Programs
7.05 Required Policies
7.33 Supervision
7.34 Curriculum, Activities, and Equipment
7.35 Physical Facility Requirements

For more information, contact:

MA Department of Public Health
Bureau of Communicable Disease Control
305 South Street
Jamaica Plain, MA 02130
Phone: (617) 983-6800
www.state.ma.us/dph

MA Department of Food and Agriculture
Bureau of Animal Health
251 Causeway Street, Suite 500
Boston, Ma 02114-2151
Phone: (617) 626-1700
www.massdfa.org

Max Care Health Line (800) 487-1119 Technical assistance from staff of Max Care: Maximizing the Health and Safety of Children in Out-of-Home Care the Healthy Child Care America project at the Department of Public Health.

Pet Industry Joint Advisory Council (PIJAC)
1220 19th Street, NW, Suite 400 Washington, DC 20036
http://petsforum.com/PIJAC/
This organization promotes the interests of the pet industry and develops aids to enhance humane and responsible care within the pet industry. Posters for safe reptile handling available called *Safe RHEX* (Reptile Handling EXcellence).

Reptile-Associated Salmonellosis -- Selected States, 1996-1998, Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, November 12, 1999 / 48(44); 1009-1013

Public Health Fact Sheet — Hepatitis A

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is hepatitis A?

Hepatitis A, also called infectious hepatitis, is a contagious viral disease that makes the liver swell. It can take from 15 to 50 days to get sick after being exposed to the hepatitis A virus. The average is about a month.

What are the symptoms?

The symptoms depend on the person's age. Adults and teens are more likely to have the classic symptoms of fever, fatigue, loss of appetite, nausea, and jaundice. The signs of jaundice include dark brown urine and pale stools (feces). The whites of the eyes turn yellow, as can the skin of light-skinned people. Young children with hepatitis A often have mild flu-like symptoms, an upset stomach, or no symptoms at all. They seldom get jaundice. Hepatitis A symptoms last a week or two. Some adults can feel sick for as long as a few months, but this is rare.

How is hepatitis A spread?

The hepatitis A virus is usually found in the stools (feces) of infected people. The virus is most likely to be spread when people do not wash their hands after using the toilet or changing a diaper or soiled sheets, then touch their own mouths, prepare food for others, or touch others with their contaminated hands. This spreads the disease from person to person. It can also be spread by contaminated food (such as shellfish) or water.

The time of highest risk for spreading the virus to others is during the two weeks before symptoms begin. Most people stop being contagious one week after their symptoms start. Unlike other hepatitis viruses, hepatitis A virus is usually not spread by blood.

Who gets hepatitis A?

Anyone can. People who live with or have sex with people who have the disease are at high risk of catching it. Hepatitis A sometimes spreads among young children in day care because many are in diapers and cannot wash their own hands, and no one knows they have the disease because they have no symptoms. Spreading the virus among school-aged children is less common because they are more likely to have symptoms, and most have learned to wash their hands before eating and after using the toilet.

How is it diagnosed?

A blood test looks for antibodies that fight the virus. This blood test can tell the difference between a current infection and a past one. There are also blood tests to measure how much damage has been done to the liver, but these tests do not show what caused the damage.

How is hepatitis A treated?

There is no treatment for the disease, and most people do not need any. Problems such as retaining fluid and blood abnormalities are rare, but they can be treated.

How can you prevent hepatitis A?

- **Wash your hands.**

  Good handwashing protects you against hepatitis A and many other diseases. Always wash your hands thoroughly with soap and water before touching food or eating and after using the toilet or changing a diaper.

- **Cook shellfish.**

  Don’t eat raw or undercooked shellfish. Thorough cooking destroys the hepatitis A virus.

- **Get hepatitis A vaccine if:**
  - You plan to travel to or work in a country with high rates of hepatitis A (Mexico; all Central and South American countries; all African, Caribbean and Asian countries except Japan; and the countries of southern and eastern Europe).
  - You live in a community with high rates of hepatitis A (Native American reservations, Alaskan Native villages, Pacific Islander villages, and some Hispanic and religious communities).
  - You have chronic liver disease.
  - You have a bleeding disorder and get clotting factors.
  - You use street drugs of any kind.
  - You are a man who has sex with other men.
- **Get immune globulin (IG) if:**
  - You did not get the vaccine and become exposed to hepatitis A. IG works best if you get it within 2 weeks after being exposed.
  - You are allergic to the vaccine or chose not to get it, and you will be traveling in an area with high rates of hepatitis A.
- **Get immune globulin (IG) for your children if:**
  - They are under 2 years old and will be traveling or living with you in an area with high rates of hepatitis A. They will need IG because the vaccine cannot be given to children until they are 2 years old.

Will IG make you immune to hepatitis A?

No. IG only partly protects you against hepatitis A virus for 3 to 5 months. You can still get the disease and spread it to others, but IG can make your symptoms milder. If you think you might be exposed again, you should talk to your doctor about getting hepatitis A vaccine, which protects for many years.

Are there any health regulations for people with hepatitis A?

Yes. Because hepatitis A can easily be spread to other people, doctors are required by law to report cases of hepatitis A to the local board of health. To protect the public, workers who have hepatitis A cannot work in any food business until their fevers are completely gone and a week has passed since their symptoms started. Coworkers may need to get IG. The term “food business” includes restaurants, sandwich shops, hospital kitchens, dairy or food-processing plants, and any other place where workers handle food or drinks, give oral care (such as brushing people's teeth), or dispense medicines.

Where can you get more information?

- Your doctor, nurse or clinic
- Your local board of health (listed in the phone book under local government)
- The Massachusetts Department of Public Health Division of Epidemiology and Immunization at (617) 983-6800 or on the MDPH website at http://www.magnet.state.ma.us/dph/

Bureau of Communicable Disease Control

- HIV/AIDS Surveillance
- Epidemiology & Immunization
- Tuberculosis Prevention & Control
- STD Prevention
- Refugee & Immigrant Health

Related Sites

- CDC Division of HIV/AIDS Prevention
- HIV/AIDS Bureau
- STD/HIV Prevention Training Center of NE

Important Numbers

National STD/AIDS Hotline	English (800) 342-AIDS Spanish (800) 344-7432
AIDS Action (MA)	(800) 235-2331
American Social Health Association (ASHA)	(800) 227-8922

Contact Information

Bureau of Communicable Disease Control
State Laboratory Institute
305 South Street
Jamaica Plain, MA 02130

Paul Etkind, DrPh, MPH
Directory, STD Prevention

Tel	(866) 749-7122
Fax	(617) 983-6962

Public Health Fact Sheet - Hepatitis B

What is hepatitis B?
Hepatitis B is a serious viral disease, and is responsible for an estimated 4,000 to 5,000 deaths each year in the United States due to liver damage (cirrhosis) and liver cancer. Most people who get the disease recover from it and can never get it again. However, about 10% of the people who get the disease will carry the virus for a long time and during this time can pass it on to others. Symptoms of hepatitis B infection include weakness, feeling ill, loss of appetite, fever, headaches, yellow skin and eyes (jaundice), dark urine, and pain in muscles, joints and the stomach. Long-term or chronic illness can lead to liver damage, liver cancer and death. Symptoms can begin as soon as six weeks or as long as 6 months after contact with the virus. Many people have mild symptoms and some do not notice symptoms at all.

Is hepatitis B dangerous?
Yes. Most adults (about 90%) who get it will get better within six months, but some will carry the virus for a long time (chronic carriers). Infants born to infected mothers often become chronic carriers. These carriers can develop chronic liver problems, which can lead to liver cancer, cirrhosis (liver failure), and death. Carriers have the virus in their body fluids and can infect their families, housemates, and sex partners. Each year in the United States, 80,000 people develop new hepatitis B infections, and as many as 11,000 of them are hospitalized.

How is hepatitis B spread?
Hepatitis B virus (HBV) is spread by contact with the blood, semen, vaginal fluids, or certain other body fluids of an infected person. When these fluids enter a person's blood through mucous membranes (such as those in the mouth or sex organs) or breaks in the skin, the virus can also enter. The virus can be spread by having sex without a condom or by sharing needles (for shooting drugs, ear or body piercing, or tattooing) with an infected person. Health care workers who get stuck by used needles can get infected. Pregnant women who have the virus in their blood can pass it to their babies while giving birth. Sharing a toothbrush, razor, or anything else that might have blood on it can also spread the virus. HBV is 100 times more contagious than HIV. About 1 of every 3 people infected with the hepatitis B virus in the U.S. does not know where they got their infection.

Can it be treated?
Most people with hepatitis B get better without treatment. Some forms of chronic hepatitis B infection can be treated with a drug called interferon.

How can you prevent hepatitis B?
The best way to prevent hepatitis B is to avoid contact with the body fluids of infected people. This means using condoms when you have sex, wearing latex gloves if you handle body fluids such as blood, and never sharing a needle, toothbrush, razor or anything else that might have blood on it.

Protect your children by having them vaccinated with 3 doses of hepatitis B vaccine before they are 18 months old. All three doses are needed for full and lasting immunity. People who have not had the vaccine and become exposed to the virus should get a shot called HBIG, as well as the vaccine. HBIG will protect you right away, but it will only work for a few months. After three doses, hepatitis B vaccine protects most people for at least 15 years. Adolescents 11 to 15 years of age may need only two doses of hepatitis B vaccine, separated by 4-6 months. Ask your health care provider for details.

Women should be tested for hepatitis B every time they get pregnant. If they have the virus, their infants will need HBIG and vaccine soon after they are born to protect them against the disease. The babies will also need two more doses of the vaccine when they are one month and six months old.

Who should get hepatitis B vaccine?

- All newborns and children through the age of 18
- Adults over 18 who are at risk

Adults at risk include people who have more than one sex partner in 6 months, men who have sex with men, sex contacts of infected people, illegal injection drug users, health care and public safety workers who might be exposed to infected blood or body fluids, household contacts of persons with chronic HBV infection, and hemodialysis patients. If you are uncertain whether you are at risk, ask your doctor or nurse.

Is hepatitis B vaccine safe?
Yes, it is safe for most people. However, a vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions, which are extremely rare with any vaccine. However, the most common problems are soreness where the shot was given or fever. Getting hepatitis B vaccine is much safer than getting hepatitis B disease, and most people do not have any problems with it.

Who should not get hepatitis B vaccine?

- People who have had a serious reaction to baker's yeast (the kind used for making bread), other vaccine component, or a previous dose of the vaccine should not get hepatitis B vaccine.
- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting hepatitis B vaccine.

Is the hepatitis B vaccine required for anyone?
In Massachusetts, the hepatitis B vaccine is required for all children who attend licensed child care or preschool, kindergarten-grade 5, and grades 7-9. This requirement will be phased in to include all grades, K through 12 by 2004. In addition, hepatitis B vaccine is currently required for all freshmen and health science students attending college. This requirement will be phased in to include all sophomores in 2002, juniors in 2003, seniors in 2004, and graduate students in 2005. OSHA requires private employers to offer hepatitis B vaccine to workers who might come into contact with blood, blood products, or other body fluids on the job.

Are there other kinds of hepatitis?
Yes. There are many kinds of hepatitis caused by viruses. The symptoms are so alike that blood tests are needed to tell them apart, but they are not all spread the same way. In the U.S., the most common types of hepatitis are A, B and C. Types B and C are spread through blood and other body fluids, but type A is spread through contaminated food, water, or stool (feces). Fact sheets on hepatitis A and hepatitis C are available from the Department of Public Health.

Where can you get more information?

- **Your doctor, nurse or clinic**
- **Your local board of health** (listed in the phone book under local government)
- **The Massachusetts Department of Public Health**, Immunization Program at **(617) 983-6800**, toll-free at

1-888-658-2850, on the MDPH web site at http://www.state.ma.us/dph/, or at the MDPH Regional offices at:

Central Region, West Boylston (508) 792-7880Metro/Boston Region*, Jamaica Plain

(617) 983-6860Northeast Region, Tewksbury (978) 851-7261Southeast Region, Lakeville (508) 947-1231Western Region, Amherst (413) 545-6600

- **Occupational Health and Safety Administration** (OSHA)Region I Office (617) 565-9860

* Boston providers/residents may also call the Boston Health Commission at (617) 534-5611.

September 2001

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is hepatitis C?

Hepatitis C is a virus (a type of germ) that causes liver disease. The hepatitis C virus is found in the blood and liver of people with hepatitis C infection.

How is hepatitis C spread?

The virus is spread primarily through blood. People most at risk are those who have had a blood transfusion or an organ transplant before 1992, or people who use or have used needles contaminated by blood (for example, the injection of drugs). Since July 1992, the blood supply has been carefully checked for this virus and the blood supply is considered to be safe.

The hepatitis C virus can be spread whenever blood (or fluids containing blood) come in contact with an opening on the skin or other tissues. This can occur even when these openings cannot be seen. Hepatitis C virus can also be transmitted by sexual contact, but this does not happen as easily as the spread of HIV, the virus that causes AIDS.

The hepatitis C virus is not spread by casual contact like hugging, sneezing, coughing, or sharing food and drinks. You can not get hepatitis C by donating blood.

How serious is hepatitis C?

Hepatitis C infection can be very serious. Most people who become infected will carry the virus for the rest of their lives. Some of these people will develop liver damage and feel very sick. Other people may feel healthy for many years after being diagnosed with hepatitis C infection. This virus can eventually cause cirrhosis (scarring of the liver) and/or liver cancer in some infected people. While most people will not develop liver failure or cancer with hepatitis C, we cannot tell who will or will not have these problems.

Who is at risk of getting hepatitis C?

People are at risk for developing hepatitis C infection if they:

- have used street drugs or shared needles, even just once;
- have received a blood transfusion, blood products, or an organ transplant before July 1992;
- have had many sexual partners, especially if they did not use condoms;
- are health care workers (like doctors or nurses) who may be exposed to blood or needles;
- are babies born to mothers who have hepatitis C; or
- have been on kidney dialysis.

Is there a treatment for hepatitis C?

A drug called interferon may sometimes be used to treat hepatitis C infection. It is usually used in combination with other drugs, such as Ribavirin. People diagnosed with hepatitis C infection should not drink any alcohol or take certain medicines that can cause liver damage. It is recommended that persons infected with hepatitis C be vaccinated for hepatitis A and hepatitis B, two other viruses which cause liver damage if they are at risk for those infections. Antibiotics (medicine to fight an infection from bacteria) do not work against the hepatitis C virus. Ask your doctor about treatment options and steps you can take to protect your liver.

How can hepatitis C be prevented?

There is no vaccine for hepatitis C. The best way to keep from getting the hepatitis C virus is to avoid any contact with blood. This includes not sharing needles, razors, or toothbrushes. Blood banks now screen donated blood for hepatitis C virus, so your risk of getting infected from a blood transfusion is extremely low. You can also get hepatitis C from sex with an infected partner; using a condom may reduce your risk of becoming infected.

To prevent the spread of hepatitis C:

- If you shoot drugs, never share works with anyone. Don't share cocaine or other snorting straws, since these can get blood on them too. Find out about treatment programs that can help you stop using drugs.
- Use a latex condom every time you have sex.
- Only get tattoos or body piercings from places using sterile equipment.
- Health care workers and people who clean up in hospitals or places where needles or sharps are used should follow standard (universal) precautions for every patient.
- If you have hepatitis C, don't share razors or toothbrushes.
- If you have hepatitis C, don't donate blood, sperm, or organs.

What about other kinds of hepatitis?

There are several different kinds of hepatitis viruses. If you have had one type, you can still get any of the others. The hepatitis A virus is spread by feces (stool) through close personal contact or contaminated food and water. Even a very small or not visible amount of feces can carry this virus. There is a vaccine to prevent hepatitis A infection. The hepatitis B virus is spread through blood and body fluids, like semen. There is also a vaccine to protect you from hepatitis B infection. If you have hepatitis C, ask your doctor about getting vaccinated for hepatitis A and B. Blood tests can be done to see if you have been exposed to the different types of hepatitis viruses.

Where can you get more information?

- Call your doctor, nurse, or health clinic
- Call your local board of health, listed in the phone book under government
- Contact:
  - The Massachusetts Department of Public Health (MDPH)
    Division of Epidemiology and Immunization, at
    (617) 983-6800, or visit the MDPH hepatitis C website at
    http://www.masshepc.org or the MDPH general website at: http://www.magnet.state.ma.us/dph/
  - The Hepatitis Hotline, at
    The Centers for Disease Control and Prevention (CDC), at
    1-888-4HEPCDC (1-888-443-7232) or the CDC website at:
    http://www.cdc.gov/ncidod/diseases/hepatitis/hepatitis.htm

October 1999

PUBLIC HEALTH FACT SHEET

Hib

Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130

What is Hib disease?

Haemophilus influenzae type B (Hib) is a serious disease caused by bacteria. It usually affects young children under the age of 5. Before Hib vaccine, Hib disease was the leading cause of bacterial meningitis among children. Hib meningitis can cause permanent brain damage. Hib can also cause swelling in the airways and lead to suffocation. Hib can infect the lungs, blood, joints, bones and the thin membrane that covers the heart.

Is Hib disease dangerous?

Yes. Before Hib vaccine, each year about 20,000 children in the United States under 5 years old got severe Hib disease and nearly 1,000 of them died.

How is Hib disease spread?

Your child can get Hib disease by being around other children or adults who may have the bacteria and not know it. It is spread by a germ from person to person. If the germs stay in the nose and throat, children probably won't get sick. But sometimes the germs spread into a child's lungs or bloodstream and then Hib can cause serious problems.

Who gets Hib disease?

Black, Latino, Native American, and poor children are at higher risk of getting Hib. Children younger than 6 who attend day care seem to be at higher risk, too. Children and adults with sickle cell anemia, no spleen,weakened immune systems or on drugs or treatments that weaken the immune system, also are at higher risk for Hib. Hib is most common in infants, but nearly half the cases occur in children age 12 months or older.

How can you prevent Hib disease?

Protect your children by having them vaccinated. All infants should get a series of four Hib shots starting when they are 2 months old. The rest of the shots are given at 4, 6, and 15 months. There are different schedules for babies between 7 and 15 months old who missed the shots when they were younger. Children 15 months through 4 years of age need at least 1 dose. Children 5 years of age and older, and adults with the special health problems described above, also need at least 1 dose.

Is the Hib vaccine safe?

Yes, it is safe for most people, but like any vaccine it can sometimes cause mild side effects. About one of every 4 children who get Hib vaccine will have a little redness or swelling where the shot was given. Up to 5 in 100 children will run a fever of 101° F or higher. These reactions are not serious and usually go away in a few days. More severe reactions can happen, but they are rare.

Who should not get Hib vaccine?

- People who have ever had a serious reaction to a previous dose of Hib vaccine
- Children less than 6 weeks of age
- People who are moderately or severely ill at the time the shot is scheduled should usually wait until they recover

Where can you get more information?

- **Your doctor, nurse or clinic**
- **Your local board of health** (listed in the phone book under local government)
- **The Massachusetts Department of Public Health** (MDPH) Immunization Program **(617) 983-6800** of toll-free at **1-888-658-2850** or on the MDPH website at **http://www.state.ma.us/dph/**, or the regional office of the MDPH immunization program:

Central Immunization Office, West Boylston	(508) 792-7880
Metro/Boston* Immunization Office, Jamaica Plain	(617) 983-6860
Northeast Immunization Office, Tewksbury	(978) 851-7261
Southeast Immunization Office, Lakeville	(508) 947-1231
Western Immunization Office, Amherst	(413) 545-6600

*For Boston providers/residents, you may also call the Boston Health Commission at (617) 534-5611.

November 1999

PUBLIC HEALTH FACT SHEET

Cytomegalovirus (CMV)

Massachusetts Department of Public Health, 150 Tremont Street, Boston, MA 02111, (617) 727-0049, Dr. Deborah Prothrow-Stith, Commissioner

What is cytomegalovirus (CMV)?

CMV is a virus that can cause a contagious but mild disease commonly found in young children. In most cases the infection causes no symptoms at all.

How common are CMV infections?

Many people have caught the virus by the time they reach young adulthood. In the United States, at least 40% of all 35-year-old adults have antibodies (virus fighters) against cytomegalovirus in their blood, which means they were once infected.

What are the symptoms of CMV infection?

Most children and adults have no symptoms at all and are not harmed by the virus. Some people may develop symptoms similar to mononucleosis. These symptoms include fever, sore throat, fatigue and swollen glands.

Why is CMV a public health problem?

While healthy people rarely show symptoms, those whose immune systems do not work properly (because of chronic illnesses or organ transplants, for example) may be severely affected by CMV infection. In these people the infection can cause fever, loss of appetite, hepatitis or pneumonia. In some cases the infection can be very severe or even fatal.

CMV can also be dangerous when a pregnant woman is infected with the virus. CMV can cause a variety of disabilities in children whose mothers become infected for the first time during pregnancy. These disabilities may include mental retardation, hearing loss and developmental delay.

How is CMV infection diagnosed?

Diagnosis is based on finding the virus in urine, saliva, breast milk, cervical secretions or semen. There are also blood tests that can show newly formed antibodies to CMV.

How is CMV infection spread?

The virus can be found in the urine, saliva, breast milk, cervical secretions or semen from a person infected with CMV. The virus is not highly contagious, but it can be spread during sex or when infected body fluids touch another person's mucous membranes (inside the nose, mouth, eyes, etc.). Newly infected women can spread the virus to their infants during pregnancy, birth or breastfeeding.

How long is someone with CMV contagious?

People with CMV are contagious as long as they excrete or "shed" the virus in body fluids. CMV can be shed in urine or saliva for many months, sometimes for years. An infant who is infected during the first month of life may shed the virus for as long as five or six years. Newly infected adults appear to shed CMV for shorter periods.

How can you protect yourself against CMV infection?

There is no vaccine against CMV and most infected people have no symptoms. Therefore, careful handwashing with soap and water after diaper changes, toilet care or contact with anyone's body fluids is important to prevent infection. Women of childbearing age who work in hospitals or preschools (especially those with special-needs students) should strictly follow standard measures of personal hygiene, including handwashing, because they are likely to have contact with children who are shedding the virus.

Should children with CMV infections be kept out of day care?

No, children who are known to have CMV infections do not need to be kept out of day care. CMV infections are so common among children that others at the center probably also have CMV but do not have symptoms.

How can you keep CMV from spreading in your preschool or day-care center?

The best prevention is to make sure all staff wash their hands after contact with secretions from any child. Since CMV is shed in urine and saliva, clothes contaminated with these fluids should be bagged separately and sent home for washing. Do not allow children to share food or mouthed objects. At least once a day, wash and disinfect any toys children put in their mouths. Use care when handling and disposing of diapers, and wash hands thoroughly with soap and water after diaper changes and toilet care.

Can CMV infections be treated?

Antibiotics cannot be used to treat CMV infections because they are caused by viruses, but treatment is not usually needed because symptoms are mild or absent. Supportive treatment is available for people with weakened immune systems who may be severely affected by CMV infection.

Where can I get more information about CMV?

Your personal doctor

Your local board of health
Listed in the telephone book under local government

The Massachusetts Department of Public Health
Division of Communicable Disease Control (617) 522-3700

October 1988

MASSACHUSETTS EARLY INTERVENTION SYSTEM
PROCEDURAL SAFEGUARDS and DUE PROCESS STANDARDS

Purpose

The purpose of these standards is to establish due process standards for public and private early intervention programs certified or funded by the Department of Public Health with respect to notice of rights, informed consent, records and confidentiality, appeals and complaints.

A. The Massachusetts Department of Public Health shall be responsible for:

1. Establishing or adopting due process procedures that meet the requirements of 34 CFR 303.400 through 303.406, 303.419 through 303.425, 303.460 and 303.510 through 303.512 and providing parents a means of filing a complaint or requesting to resolve a disagreement through mediation.

2. Ensuring effective implementation of the safeguards by each provider in the Commonwealth that is involved in the provision of early intervention services under this part.

3. Ensuring that an impartial person will be appointed to implement the complaint resolution process referred to in this section.
   a. "Impartial" as used in this section means that the person appointed:
      i. is not an employee of any agency or other entity involved in the provision of early intervention services or care of the child; and
      ii. does not have a personal or professional interest that would conflict with his or her objectivity in implementing the process.

4. Establishing or adopting policies and procedures to ensure the protection of any personally identifiable information collected, used, or maintained under this part, including the right of parents to written notice of and written consent to the exchange of this information across agencies or providers consistent with Federal and State law.

5. Ensuring that, parents of a child eligible under Part C are given notice that they may determine whether they, their child, or other family members will accept or decline any early intervention service under this Part in accordance with these due process procedures and may decline such a service after first accepting it, without jeopardizing other agreed upon early intervention services under this part.

B. These policies and procedures are intended to meet the requirements as stated in 34 CFR 300.560 through 300.576 (Part B) with the modifications specified in 34 CFR 303.5(b).

II.) Authority

These procedures are adopted pursuant to 34 CFR 303.400 - 303.406, 303.419 through 303.425, and 303.510 - 303.512

III.) Scope

These procedures govern the conduct of early intervention providers and the Department with respect to certain aspects of evaluation, assessment, eligibility for services, and the provision of early intervention services. The regulations are based upon the Department's participation in the federal Part C program.

IV.) Definitions

A. ***Days*** shall mean calendar days.

B. ***Early intervention services*** shall mean those services specified in 34 CFR 303.12, 303.13 and 303.14.

C. ***Parental consent*** shall mean that:

1. The parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language unless clearly not feasible to do so, and shall otherwise be done in the manner best understood by the parent.

2. The parent understands and agrees in writing to the carrying out of the activity for which consent is sought ,and the consent describes that activity and lists the records (if any) that will be released and to whom; and

3. The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

The explanation shall be in the parent's native language unless clearly not feasible to do so and shall otherwise be done in the manner best understood by the parent. The parent shall have an opportunity to discuss the explanation and to have questions answered. If the explanation is not in the parent's native language, the parent shall be provided, whenever feasible, with a list of interpreters in that language.

D. ***Native language*** shall mean the language or mode of communication normally used by the parent of a child seeking or using services. If the parent has a vision or hearing impairment, the mode of communication shall be that normally used by the parent, such as sign language, Braille, oral communication or other appropriate mode of communication.

E. ***Parent*** shall mean;

1. a natural or adoptive parent of the child,

2. a guardian,

3. a person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives),

4. a person who is legally responsible for the child's welfare; or a surrogate parent who has been assigned in accordance with 34 CFR 303.406 (section VI (C). of these standards)

5. a foster parent may make decisions required of a parent under Part C of the Act if:
   a. The natural parents' authority to make decisions required of parents under the Act has been terminated under State law; and
   b. The foster parent –
      i. has an ongoing, long term parental relationship with the child;
      ii. is willing to make decisions required of parents under the requirements of these Due Process procedures; and
      iii. has no interest that would conflict with the interests of the child.

F. ***Personally identifiable*** shall mean information that includes:

1. the name of the child, the child's parent, or other family member,

2. the address of the child,

3. a personal identifier, such as the child's or parent's social security number; or

4. a list of personal characteristics or other information that would make it possible to identify the child with reasonable certainty.

G. ***Early Intervention provider*** shall mean any public or private program which offers early intervention services and which is funded or certified by the Department to provide such services.

H. ***Written informed consent*** shall mean a form or other written record which serves as evidence that the explanation required for informed consent, as defined in subsection C of this section, has been provided. The parent's signature shall serve as documentation that the parent understands and agrees to the proposed terms and activities.

I. ***Destruction*** shall mean the physical destruction or removal of personally identifiable information from all records.

J. ***Education record*** means the record covered by the Family Educational Rights and Privacy Act (FERPA:34 CFR Part 99)

K. ***Participating agency*** shall mean any agency, provider or institution, which collects, maintains or uses personally identifiable information or from which such information is obtained.

V.) Notice of Rights

A. Upon receipt of a referral or application, and upon initial development and periodic review of the Individualized Family Service Plan (IFSP), the parent shall be given a notice in writing of the process involved in arranging for and providing assessments, evaluations, and services and the rights of the parent in that process. The notice shall be written in language understandable to the general public.

1. The notice shall be in the parent's native language, unless clearly not feasible, or otherwise in the manner best understood by the parent.
    a. If the parent's native language or other mode of communication is not written, the program shall ensure that the notice is translated orally or by another means in the parent's native language unless clearly not feasible to do so and shall otherwise be done in a manner best understood by the parent;
    b. If the parent is deaf or blind, or has no written language or mode of communication, the notice shall be provided in the language/mode of communication normally used by the parent unless clearly not feasible to do so and shall otherwise be done in a manner best understood by the parent.
2. The provider will ensure that:
    a. the parent understands the notice to the maximum extent feasible;
    b. there is written evidence that these requirements have been met;
    c. the parent has been given an opportunity to discuss the contents of the notice and have questions answered.
3. The notice shall specify the right to:
    a. receive a multidisciplinary eligibility evaluation of a child from 0 through 2 years of age within 45 days of referral;
    b. if eligible, receive appropriate assessment and IFSP development within 45 days of referral;
    c. if eligible, receive appropriate services for the child and family;

d. receive notice of the opportunity to participate in any meeting where it is expected that a decision will be made about early intervention services for a child or family;
e. receive notice before a provider proposes or refuses to initiate or change an identification, placement, evaluation, assessment or service, in accordance with this section;
f. grant or refuse informed consent in accordance with section VI (A)&(B);
g. appeal a disputed matter concerning an evaluation, identification, placement, assessment or the process of IFSP development (in accordance with the section on Complaint Resolution), section IX;
h. file a complaint about non-compliance issues or any violation of Part C (34 CFR 303.1-303.654) in accordance with Section VIII.
i. confidentiality of personally identifiable information, in accordance with the definition of personally identifiable section VII;
j. review, or amend records, in accordance with section VII;
k. use a lawyer, advocate or other representative in any matter pertaining to early intervention services;
l. receive an explanation of the use of and effect upon insurance;
m. appeal a decision of a hearing officer to an appropriate state or federal court;
n. other appropriate procedural safeguards available under Part C (CFR 303.400-303.460 and 303.510-303.512

B. The parent shall be given a readily understandable written notice a reasonable time before a provider proposes or refuses to initiate or change the identification, evaluation or placement of a child, or the provision of early intervention services to the child or family.

1. The notice shall be in the parent's native language, unless clearly not feasible, or otherwise in the manner best understood by the parent.

   a. If the parent's native language or other mode of communication is not written, the program shall ensure that the notice is translated orally or by another means in the parent's native language, unless clearly not feasible to do so, or otherwise in a manner best understood by the parent;
   b. If the parent is deaf or blind, or has no written language or mode of communication, the notice shall be provided in the language/mode of communication normally used by the parent, unless clearly not feasible to do so or otherwise in a manner best understood by the parent.

2. The provider will ensure that:

   a. the parent understands the notice to the maximum extent feasible; and
   b. there is written evidence that these requirements have been met.
   c. the parent shall be given an opportunity to discuss the contents of the notice and have questions answered.

3. The notice shall specify:

   a. the action(s) being proposed or refused and what will happen with respect to actions which the parent objects to or requests;
   b. the reasons for taking the action(s); the need for informed consent, as specified in section VI (A)&(B), and the right to refuse consent;
   c. when applicable under section VIII, the right to request a mediation or due process hearing or file a complaint, and to receive services not in dispute:
   d. the right to consent to some services, evaluations, and assessments and reject others, without jeopardizing other services under this part;
   e. all other procedural safeguards available under Part C (CFR 303.401-303.460).

VI.) Parent Consent

A. Written parental consent, as defined in section IV (C), must be obtained:

1. before conducting an evaluation or assessment or a reassessment or re-evaluation. Prior to any assessment involving family members, informed consent satisfying the requirement of IV (C) shall be obtained from all involved family members;

2. at the time the initial IFSP and any subsequent IFSP is developed or any revisions are made to an IFSP;

3. before a change in identification, placement, evaluation, assessment, or reduction in services or change in the type of services.

B. If a parent does not give consent, the program must make an effort to ensure:

1. that the parent is fully aware of the nature of the evaluation, assessment or services that would be available; and

2. that the parent understands the child will not be able to receive an evaluation, assessment or services without consent.

C. Parent's Right to Decline Service

Parents may determine whether they, their child or other family members will accept or decline any early intervention service. Parents may also decline such a service after first accepting it, without jeopardizing other early intervention services.

D. Surrogates

1. The provider should, within a reasonable time of application or referral, assign a surrogate to represent the rights of eligible children in the following circumstances:

   a. when the provider, after reasonable efforts, is unable to identify or locate the parent, guardian or person acting as parent of a child (this includes a foster parent as specified in Sec IV (E, 5.) unless he or she indicates or demonstrates an unwillingness or inability to serve in this capacity);

   b. when the child is in the legal custody of a state agency.

      i. If the foster parent is unwilling or unable to serve as "parent" for the child, the provider, with the assistance of the IFSP team, should endeavor to appoint an effective advocate for the child, with preference given to someone who is known to the child and family and has an understanding of the child and family's cultural, linguistic and religious background.

      ii. The provider will ensure that the person selected as a surrogate parent has knowledge and skills that ensure adequate representation of the child; and that the surrogate is impartial, has no interest which conflicts with the child's interests and is not an employee of the provider or any other agency providing early intervention services to the child or to any family member of the child, the Departments of Public Health or Social Service, or any other state agency involved in the provision of services to the child.

      iii. Even when there is a surrogate appointed, if reunification of the child and the natural parent is the goal of the DSS service plan, the provider shall make every effort to have the natural parent participate in decision making about the provision of services, unless the natural parent's rights to participate have been terminated by judicial process.

2. The surrogate shall have the same rights as a parent under these standards, including the right to consent, revoke or withhold consent and to represent the child in all matters pertaining to evaluation, assessment, IFSP development, the provision of early intervention

services and any other rights established under this part.

3. In the event that the provider is unable to identify a suitable surrogate for a child in state custody, the Department shall appoint a surrogate. The Department shall maintain a list of approved surrogates and procedures for appointing a surrogate from that list.

   a. The Department shall endeavor to appoint an effective advocate, with a preference given to a person with an understanding of the child and family's cultural, religious and linguistic background.

   b. The Department shall ensure that the person selected as a surrogate parent has knowledge and skills that ensure adequate representation of the child; he/she will be knowledgeable and trained in the developmental needs, service options, and legal rights of children eligible for early intervention services, shall be impartial, have no interest which conflicts with the child's interests and shall not be an employee of the Department, the Department of Social Services or a provider; provided, however, that such person may be paid by the Department for serving as a surrogate.

VII.) Records

A. Definition

1. A ***record*** is any information, regardless of location, recorded in any way, maintained by an agency or service provider or any party acting on behalf of the agency or service provider.

2. A ***record*** includes any file, evaluation, report, study, letter, telegram, minutes of meetings, memorandum, summary, intra-office communications concerning an individual, notes, charts, graphs, data sheets, films, videotapes, slides, sound recordings, discs, tapes and information stores in microfilm or microfiche or in computer readable form.

B. Parent Access

1. The Department of Public Health and the provider shall presume that the parent has the authority to review and inspect records related to the child unless the Department or provider has been advised that the parent does not have this authority under state law.

2. The Department or provider shall, within five days of request, give the parent a list of the types and locations of records collected, maintained or used by the Department or provider.

3. The parent shall be afforded the opportunity to inspect and review any such record relating to evaluations, assessments, eligibility determination, development and implementation of IFSP, due process hearing, individual complaints dealing with the child, and any other area involving records about the child/family. This includes all records collected and maintained by the provider. The provider should notify all parties asked to submit records for a child's file that they are open to the parent under the provisions of 34 CFR 303.402 and 34 CFR 300.560 through 300.576.

4. The right to review a record includes the right to an explanation or interpretation of the record and the right to have a representative of the parent view the record and the right to request that the agency provide a copy of the records containing the information. Agencies may charge a reasonable fee for copying records, if the fee does not prevent the parent from exercising the right to inspect and review records. Agencies may not charge fees to search for or retrieve records.

5. An agency or service provider shall comply without unnecessary delay and no later than 10 days of receiving the request.

6. Where records are requested in connection with a meeting regarding the IFSP or a formal hearing, the agency or service provider shall comply at least five days before the meeting or hearing.

7. If a record contains information on more than one child, the parent has a right to inspect only those portions of the record pertaining to his or her child.

C. Amending the Record

1. If a parent feels that the information in early intervention records that is collected, maintained, or used is inaccurate, irrelevant, misleading, or violates the privacy or other rights of the child, he/she may request that the participating agency which maintains the records to amend the information.

2. The holder of the record shall respond within 30 days. If the holder of the record finds that the objection is valid, it shall amend the contents of the records or the methods for holding or using such data and duly notify the parent in writing. If the holder refuses to amend the record, it shall so notify the parent in writing of the decision, the right to appeal pursuant to section VIII, and the right to place a statement in the record reflecting the parent's views, which would be maintained and disseminated with the rest of the record.

3. In responding to a parent's objection, the holder of the record may not amend the contents of a record that was submitted to the child's file by a source outside of the provider agency. The provider may agree to amend the record by placing a statement in the record reflecting the parent's (and/or the provider's) views and direct the parent to contact the originator of the record to request that a corrected copy be placed in the file.

4. A parent, upon request, must be granted a hearing to challenge information contained in an early intervention educational record.

    a. such a hearing shall be conducted under procedures in section 99.22 of the Family Educational Rights and Privacy Act (FERPA: 34 CFR Part 99);
    b. If the hearing officer finds that the information is inaccurate, misleading, irrelevant, or violates the privacy or other rights of the child or family, the record shall be amended and the parent so notified in writing.
    c. If the hearing officer finds that the information is not inaccurate, misleading, irrelevant, or not a violation of the privacy or other rights of the child and family, the parent shall be informed of the right to place in the record a statement of the parent's views. This statement shall be maintained by the agency for as long as the contested part of the record is maintained, and disseminated with the record.

D. Confidentiality

1. The Department of Public Health and providers shall ensure the protection of confidential personally identifiable information at collection, storage, disclosure and destruction stages.

2. All records and information pertaining to a child or family shall be confidential. All holders of personally identifying information shall comply with the confidentiality provisions of M.G.L. c. 66A and related regulations. All records must contain an access sheet that keeps record of parties obtaining access to the record. This sheet must list the name of the party requesting access, and the date and purpose of access.

    a. Records and personally identifying information shall not be disclosed, even to prospective providers of services, without the parent's written informed consent; provided, however, that records may be inspected by health personnel in response to a health or safety emergency or by state and federal agencies for purposes of audit, evaluation for compliance with legal and contractual requirements, and certification. Personally identifiable information shall not be

used for purposes other than meeting the requirements of this part without parental consent. Beyond these exceptions any additional release of information will not occur without parental consent.

b. The Department and each provider shall appoint an employee responsible for ensuring confidentiality. The Department and each provider shall maintain a current list of employees with access to personally identifiable information and shall provide these employees with training concerning the state's policies and procedures under 34 CFR 300.129 and 34 CFR Part 99 (FERPA). Supervision and monitoring procedures will ensure that all providers meet confidentiality requirements.

3. A record holder shall establish written procedures which protect the contents of early intervention records containing sensitive information, such as information pertaining to sexual or physical abuse, mental health treatment, HIV or other communicable disease status, or a child's parentage.

4. If the Department or provider maintains personally identifying early intervention information not subject to the Family Educational Rights and Privacy Act (FERPA: 34 CFR Part 99), it shall protect that information pursuant to the confidentiality provisions of 5 USC 522A and related regulations.

5. Upon discharge from early intervention services, the provider shall notify the parent that personally identifiable information is no longer needed to provide services to the child or family. Such information must be destroyed at the request of the parent, or the provider may destroy it after seven years. However, a permanent record may be maintained without time limitation of the child and family's name, address and phone number, and the types and dates of services received.

6. The Department and program shall meet any additional confidentiality requirement specified in 34 CFR 300.560 - 300.576 with the following modifications:

   a. any reference to the "State Education Agency" means the Department of Public Health;
   b. any reference to "special education", "related services", "free appropriate public education", "free public education" or "education" means the provision of early intervention services;
   c. any reference to "local education agencies" and "intermediate educational units" means certified early intervention programs;
   d. any reference to "Identification, Location and Evaluation of the Child with Disabilities" means "Comprehensive Child Find System."
   e. any reference to "Confidentiality of Personally Identifying Information" means "Confidentiality of Information";
   f. any reference to "education records" means the type of records covered under the definition of education records in Part 99 of the Family Educational Rights and Privacy Act of 1974 (FERPA);
   g. any reference to "participating agency" when used in reference to a local educational agency or an intermediate educational agency, means a local service provider;
   h. any reference to "destruction" means physical destruction or removal of personal identification from information.

VIII.) Lead <u>Agency Procedures for Complaint Resolution</u>

The Department of Public Health offers parents of children enrolled in Massachusetts early intervention programs and others, options for the resolution of complaints and/or disputes. The following procedural

safeguards reflect the federal regulations of Part C of IDEA (34 CFR 303.419-303.425 and 303.510-512) and provide parents a means of filing a complaint or requesting to resolve a disagreement through due process in a timely, impartial and consistent manner.

1. In accordance with 34 CFR Sec. 303.510 – 303.512, the Massachusetts Department of Public Health shall be responsible for adopting written procedures to (1) investigate any complaint that it receives (including individual child complaints and those that are systemic in nature) and (2) resolve the complaint if the agency determines that a violation has occurred. This includes a complaint filed by an organization or individual from another State indicating that any public agency or private service provider is violating a requirement of the regulations as stipulated by Part C of the Individuals with Disabilities Education Act (IDEA).

2. All such complaints and requests for mediation and/or due process hearings shall be filed with the Department.

3. Information on the availability of this type of administrative complaint resolution process shall be widely disseminated to parents and other interested individuals, including parent training centers, protection and advocacy agencies, independent living centers and other appropriate entities, the States procedures under Sections 34 CFR 303.510 through 303.512.

A. Formal Administrative Complaints

1. In resolving a complaint in which it finds failure to provide appropriate services, the Department will address:

    a. How to remediate the denial of those services, including, as appropriate, the awarding of monetary reimbursement or other corrective action appropriate to the needs of the child and the child's family; and
    b. Appropriate future provision of services for all infants and toddlers with disabilities and their families.

2. In accordance with CFR Sec. 303.511, an individual or organization may file a written, signed complaint under Sec. 303.510. The complaint must include:

    a. A statement that the State or early intervention provider has violated a requirement of Part C of the IDEA or the regulations in this part; and the facts on which the complaint is based.
    b. Limitations. The alleged violation must have occurred not more than one year before the date that the complaint is received by the Department unless a longer period is reasonable because:
        i. the alleged violation continues for that child or other children; or
        ii. the complainant is requesting reimbursement or corrective action for a violation that occurred not more than three years before the date on which the complaint is received by the public agency.

3. In accordance with 34 CFR Sec. 303.512:

    a. The Department shall include in its complaint procedures a time limit of 60 calendar days after a complaint is filed under Sec. 303.510(a) to:
        i. carry out an independent on-site investigation, if the Department determines that such an investigation is necessary;
        ii. give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;

iii. review all relevant information and make an independent determination as to whether there has been a violation of a requirement of Part C of IDEA or of this Part; and

iv. issue a written decision to the complainant that addresses each allegation in the complaint and contains findings of fact, conclusions and the reason for the lead agency's final decision. The Department's procedures may permit an extension of the time limit under paragraph (a) of this section only if exceptional circumstances exist with respect to a particular complaint.

v. include procedures for effective implementation of the Department's final decision, if needed, including—

- technical assistance activities;
- negotiations; and
- corrective actions to achieve compliance.

4. If a written complaint is received that is also the subject of a due process hearing under Sec. 303.420, or contains multiple issues, of which one or more are part of that hearing, the Department will set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action will be resolved within the 60-calendar-day timeline using the complaint procedures described in paragraphs (3) (a) and (b) of this section.

5. If an issue is raised in a complaint filed under this section that has previously been decided in a due process hearing involving the same parties—

   a. The hearing decision is binding; and
   b. The Department must inform the complainant to that effect.

6. The Department will resolve a complaint alleging a public agency's or private service provider's failure to implement a due process decision.

IX.) Requests for Due Process Hearings and Mediations

A. Filing:

1. A parent or early intervention provider may file a request for a due process hearing and/or mediation under this subsection on any issue in dispute as to identification, evaluation, assessment, determination of eligibility, the process of developing the IFSP, and the appropriateness of early intervention services to be provided. A parent or provider may also seek resolution of a dispute by filing a complaint pursuant to section VIII.

   a. A request for a due process hearing or mediation shall be in writing. As needed or requested, the Department shall assist the parent in drafting and filing the hearing or mediation request.
   b. Within three days of receiving a request for a due process hearing or mediation under this subsection (A), the Department shall notify the parent of free or low cost legal and advocacy services, and of the right to be advised by an individual with special knowledge of early intervention services; the option of mediation, including a description of the mediation process and its voluntary nature; and the alternative of having the Department investigate the complaint pursuant to 34 CFR 303.510 through 303.512. The Department shall also send the parent a copy of the notice of rights specified in this section.
   c. During the pending process of appeal or mediation, the child and family shall be entitled to those services which are currently being provided or, if initial services, are not in dispute. If there is a dispute between agencies or providers as to payment for early intervention services provided under the IFSP, the Department shall ensure the provision of services without charge until the dispute is resolved.

B. Mediation Process:

1. Whenever a hearing is requested, parties must be offered the choice to resolve their disputes through a mediation process. Mediation may also be offered and accessed at any time to resolve a dispute. If mediation is requested, the Department shall promptly appoint a qualified and impartial mediator who is trained in effective mediation techniques. The mediator shall promptly schedule a meeting to be held within 14 days, unless otherwise requested by the parent, at a mutually convenient time and place.

2. The Department will send the parent(s) a list of free of low-cost attorneys and advocates who may be available to assist parents through the process.

3. The Department will ensure that the mediation process is:

   a. voluntary on the part of the parties;
   b. is not used to deny or delay a parent's right to a due process hearing or any other rights afforded under 34 CFR Sec. 303.400 – 303.460 and 303.510-303.512;
   c. is conducted by a qualified and impartial mediator.

4. The Department shall maintain a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of special education and related services.

5. The Department shall bear the cost of the mediation process.

6. Each session in the mediation process must be scheduled in a timely manner and must be held in a location that is convenient to the parties.

7. A parent may proceed with the hearing process while engaged in mediation. A parent may also request mediation at any time in the hearing process.

8. An agreement reached by the parties to the dispute in the mediation process must be set forth in a written mediation agreement.

9. Discussion that occurs during the mediation process must be confidential and may not be used as evidence in any subsequent due process hearing or civil proceedings, and the parties to the mediation process may be required to sign a confidentiality pledge prior to the commencement of the process.

C. Procedures to Address the Requests for Due Process Hearing

1. Upon receipt of a request for due process hearing under this section, the Department shall promptly appoint an impartial hearing officer who shall be knowledgeable about the provisions of Part C and the needs of and services available to eligible children. Such hearing officer shall be impartial, and shall not have a personal or professional conflict of interest that interferes with objectivity. The hearing officer shall not be an employee of the Department, or an agency or provider involved in the provision of early intervention services to, or care of the child; provided, however, that such person may be paid by the Department to serve in the capacity of hearing officer.

2. If a parent initiates a request for a due process hearing, the Department will inform the parent of the availability of mediation described in section IX B (34 CFR 303.419).

3. The Department will send the parent(s) a list of free of low-cost attorneys and advocates who may be available to assist parents through the process.

4. The hearing officer shall: promptly arrange for a hearing at a time and a place that is reasonably convenient to the parents and duly notify the parties; listen to the presentation of the relevant viewpoints about the issue(s) in dispute; examine all information relevant to the issues; seek to reach a timely resolution of the complaint; provide a record of the proceedings and mail a written decision to each of the parties.

5. The pre-trial and hearing process shall be governed by the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.00, and shall include the right to present evidence, and confront, cross-examine and compel the attendance of witnesses. In addition, the parent shall have the right to:

   a. have the child and family be accompanied and advised by their own legal counsel and by other individuals with special knowledge or training with respect to early intervention services;
   b. have the hearing closed to the public, unless otherwise requested by the parents;
   c. prohibit the introduction of evidence not disclosed at least five days prior to the proceeding, unless agreed to by the parties;
   d. have the child, who is the subject of the hearing, present;
   e. be provided with an interpreter whenever feasible at no charge, if required for proper adjudication of the matter;
   f. be provided with an electronic, or if unavailable, a written verbatim transcription of the proceeding;
   g. obtain written findings of fact and a written decision.

6. A decision shall be rendered within 30 days of receipt of the request for a hearing.

7. Not later than 30 days after the receipt of a parent's complaint, the parties shall be notified by mail in writing of the decision, the reasons for the decision, all relevant findings of fact and conclusions of law, and the right to appeal the decision in state or federal court.

8. The Department will maintain a central file of decisions, which shall be a public record with the exception of personally identifying information.

9. The hearing officer's decision shall be promptly implemented.

D. Status of Child During Proceedings

1. During the pendency of any administrative or judicial proceeding involving a request for a due process hearing under section IX.B. and C. (CFR 303.420), unless the public agency and parents of a child otherwise agree, the child must continue to receive the appropriate early intervention services currently being provided.

2. If the proceeding involves an application for initial services under this section, the child must receive the agreed upon service.

3. This section does not apply if a child is transitioning from early intervention services under this part to preschool services under Part B of the IDEA.